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Attitudes of nurses to palliative care in nursing homes in the Perth metropolitan region

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**ATTITUDES OF NURSES TO PALLIATIVE CARE IN NURSING
HOMES IN THE PERTH METROPOLITAN REGION**

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**A Thesis submitted in Partial Fulfilment of the
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USE OF THESIS

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Abstract

Zanna and Rempel (1988) have proposed that attitudes are a summary evaluation of an attitude object based on three classes of information, namely: cognitive information, affective information and behavioural information. This model has mainly been tested in the social groups and social policies area investigating two classes of information: cognitive and affective, and therefore there is a need for research to test the validity of this model in other areas. The present study applies the model to the area of palliative care in nursing homes. 76 directors of nursing, 76 clinical nurse specialists, and 76 nursing assistants working in nursing homes, completed a questionnaire in which they were asked (a) to make an evaluation of their overall attitude on a 7-point semantic differential scale, (b) to write down their own beliefs and (c) affects in response to the attitude object "palliative care in nursing homes" and then rate these beliefs and affects on a 7-point Likert Scale (d) to answer 18 factual knowledge questions about palliative care, and (e) to supply some demographic information. The results indicated that cognitive and affective information significantly and independently predicted the attitudes of nurses to palliative care in nursing homes. Furthermore, knowledge contributed significantly to the attitudes of directors of nursing and clinical nurse specialists to palliative care in nursing homes after cognitive and affective information were statistically controlled, but did not contribute significantly to the attitude of the registered nurses or nursing assistants. The extent of their

education about palliative care did not predict nurses' attitudes to palliative care in nursing homes. Nurses who were currently working in palliative care had significantly more positive attitudes than other nurses, but nurses who had previously worked in palliative care showed no difference in their attitude. There is an emphasis on education in the literature which does not take into account beliefs and emotions of the nurses. Further research needs to examine the type of education that nurses receive and take into account not only their beliefs but also their emotions.

Declaration

I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any institution of higher education; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

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CHAPTER 1

Research on Palliative Care

1.1 Rationale

Palliative care may be defined as the care of a patient with a terminal illness, requiring specialised skills from a professional management team in order to provide optimum symptom control, as well as the provision of support for the emotional needs of the patient and their family (Blackburn, 1989).

This concept of care could be available to terminally ill people in the setting of their choice and not be restricted to specialised places (Chekryn & Pfaff, 1988). Although palliative care has developed as a field in its own right, it has been an unpopular area as doctors encounter obstacles in obtaining resources and acceptance within the medical profession. However, there has recently been a renewed interest in the psychosocial aspects of medical illness by mental health professionals and medical personnel (Oliver, 1992).

Recently the Western Australian Hospice Palliative Care Association Research Group was established to improve the lack of information on palliative care. A recommendation by this group suggests that residents in nursing homes should receive palliative care where appropriate, as palliative care is not available in all nursing homes in Western Australia.

As palliative care is an emerging field in its own right, many of the studies have been concerned with clarifying definitions of terminology used in palliative care, and identifying the skills and knowledge needed by physicians and nurses to practise palliative care. Although there has been interest in the education of physicians and nurses in palliative care, there has been little psychological research into palliative care or the role of the attitudes of nurses to the practice of palliative care.

Attitude theory provides a framework in which the concept and understanding of the attitude of nurses to palliative care can be based. Over the years there have been many developments within attitude theory. An examination of the empirical and historical literature suggested the use of the term "attitude" be based on a model proposed in 1988 by Zanna and Rempel which considered an attitude as a summary evaluation of an object based on three classes of information, namely: cognitive information, affective information and behavioural information. This model of attitudes aims to explain which class of information is the better predictor of the attitude and has mainly been tested in the social groups and social policies area. There appears to be a need therefore for research to test the validity of this model in other areas which will then help clarify the area of attitudes.

As the different components can influence the attitude either separately or together and be possible contributors to a particular attitude, behavioural information will not be examined. This thesis investigates the relationship

between the attitudes to palliative care and two classes of information: beliefs about palliative care (cognitive information) and emotions concerning palliative care (affective information), of nurses in nursing homes in the Perth metropolitan region. The relationship between knowledge and attitudes will be investigated. Palliative care will be discussed in this chapter, and attitudes will be examined in the following chapter.

1.2 Definition of palliative care

Palliative care has been defined as “the active total care, by a multiprofessional team, of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families” (World Health Organisation, 1990).

A further definition comes from The Australian Association of Hospice and Palliative Care who state that it is “a concept of care which provides coordinated medical, nursing and allied services for people who are terminally ill, delivered where possible in the environment of the person’s choice, and which provides physical, psychological, emotional and spiritual support for patients, families and friends. The provision of Hospice and Palliative Care Services includes grief and bereavement support for the family and other

carers during the life of the patient and continuing after death” (cited in East Metropolitan Palliative Care Agency Brochure, 1995).

Fundamental to both these definitions is the idea that palliative care operates when there is no cure for the terminally ill patient. There are two main aspects of the Australian Association of Hospice and Palliative Care definition which are absent from the World Health Organisation definition. Firstly, the definition stresses that palliative care can be administered in any environment which is the choice of the person who is terminally ill; secondly, the definition includes grief and bereavement support for the family and other carers, which occurs during the life of the patient and after death.

In addition to the stated objectives within these definitions, James (1993) identified additional objectives for palliative care. These objectives are to relieve physical and non-physical symptoms of advanced disease; to influence caring in the chosen environment; to support patients, families, other caregivers and staff before and during bereavement; to facilitate and coordinate communication between different agencies; and through education to establish this type of care in all medical facilities. In summary, Kristjanson (1989) concluded that palliative care was fundamental in addressing the emotional, physical, social and spiritual needs of terminally ill patients and their caregivers. The basis of palliative care is that the patient and family are treated as one unit (Reimer & Davies, 1991). Palliative care also aims to relieve terminally ill patients from pain and keep them physically comfortable

as far as possible. Alongside their physical symptoms, patients may experience emotional distress such as anxiety, sadness, fear or irritability so palliative care provides counselling and attention to decrease this distress (Miller & Walsh, 1991). Patients are not isolated but viewed as part of a social network with additional comfort and support provided by family and friends (Blackburn, 1989).

1.3 History of palliative care in Western Australia

Historically, palliative care has been developed through the hospice movement. A hospice may be defined as a home which is devoted to the care of the terminally ill and which provides comprehensive palliative services with the aim of making the experience of dying less unpleasant (Oliver, 1992).

The Cancer Council commissioned Dr David Frey to examine the feasibility of establishing a hospice in Western Australia in 1980. The recommendation of Frey's feasibility study was to establish a pilot project for three years, operated by an independent team providing care to terminally ill patients and their families (Oliver, 1992). The main aim of this group was to advise the Cancer Council on programs to help cancer patients in Western Australia, and to establish the Hospice/Palliative Care Service. In 1982, the Hospice/Palliative Care Service (H.P.C.S.) was established by the Cancer Council and the Silver Chain Nursing Association. At the same time that in-patient units were being formed in 1983, the Cancer Foundation decided to

hand over all administration of the established home service of patients to the Silver Chain Nursing Association.

A Palliative Care Unit at Hollywood Repatriation General Hospital was the first to be established in Perth in January, 1981 (Oliver, 1992). Another Palliative Care Unit, the Queenslea Hospice Unit at Bethesda Private Hospital was opened in 1983. The success of these units indicated that further facilities were needed. Due to planning difficulties and opposition within community and government ranks, Queenslea Hospice Unit at Bethesda Private Hospital was not extended, and in fact was closed in 1985 (Oliver). However the Cancer Foundation explored other options for providing a new facility. The Cottage Hospice was opened in 1987 and, as Oliver indicates, it has been considered successful by many of those who work in the hospice unit.

Palliative care in Perth is currently served by the Silver Chain Hospice Care Service, the Cottage Hospice, the Palliative Care Unit at Hollywood Hospital, and a small facility at Fremantle Hospital. There is also a consultative service at Royal Perth Hospital. However, Chekryn and Pfaff (1988) expressed the view that nursing homes are a medical facility which have been overlooked in the provision of palliative care. There are many elderly people who are terminally ill in these nursing homes, and for whom palliative care is one of the options that the Western Australian Research Committee on Palliative Care advise be available to them. However, not all nursing homes in the Perth Metropolitan area offer palliative care to residents

who are terminally ill. At present, no research data on the attitudes to palliative care of nurses who work in nursing homes, is available. Moreover, the Western Australian Research Committee on Palliative Care has recommended that research into palliative care in nursing homes needs to be undertaken (personal communication, 1995). In the nursing homes, the administrative work is carried out by the directors of nursing with assistance from the clinical nurse specialists. Resident care is supervised by the clinical nurse specialists and executed by the registered nurses with assistance from the nursing assistants. The directors of nursing, clinical nurse specialists and registered nurses are trained nurses, while the nursing assistants have no formal education in nursing. In this thesis, the nursing staff in general are referred to as "nurses", though it is recognised that directors of nursing, clinical nurse specialists and registered nurses are registered as nurses with the Board of Nursing.

1.4 Administration of palliative care by nurses

Palliative care is practised in the environment preferred by the terminally ill person, which may vary from the person's home to specialised hospices (Dunne and Falkenhagen, 1988). However, due to greater urbanisation, increase in technology and advancements in medical treatment, together with less community support and the availability of families, health care has become institution based (Ajemian, 1992). In view of this, hospitals

and health care facilities generally play a key role in the palliative care of patients (Ajemian).

However, according to Ajemian, the availability of palliative care beds is unequal and unpredictable from community to community, which suggests that there may not be universal access to palliative care for terminally ill patients particularly in rural areas and areas where choice is wanted. The choice of physician may impact on the type of care received. Similarly Byock (1994) suggested that hospice services are accessed by a relatively small number of patients because of inadequate public knowledge about the facilities available, and bureaucratic and financial obstacles. She further commented that palliative medicine is yet to be accepted by many areas within the medical establishment.

Ajemian (1992) proposed that the requirements of palliative care patients need to be identified by hospitals and health care facilities. This should include the amount and quality of information that is provided to the patient, the amount of support that may be offered to the patient and the family, suggestions of optimum symptom control measures, a care plan to improve the comfort of the patient, as well as the identification of ways of advancing communication with patients and their families. Ajemian offered no empirical evidence for these comments, which were merely descriptive in nature. Perhaps the knowledge required by the health professionals who care for them also needs to be specified (Copp, 1994). Ajemian suggested that a

multidisciplinary palliative care team could assist both patients and nursing staff in the health facility. A physician who has been trained in palliative care would be able to offer optimum symptom control measures.

Studies have therefore attempted to provide the necessary palliative care knowledge to teach health care professionals, such as nurses, the specific knowledge and skills required to practise palliative care. Quint (1967) argued that without this specific knowledge, nurses would adopt the behaviour of other professionals not involved in palliative care. This was supported by Chekryn and Pfaff (1988), who suggested that if nurses have a basic knowledge of palliative care, such care should be available to everyone, not only those in specialised units.

Degner, Gow and Thompson (1991) suggested that additional teaching programs to better prepare nurses for the care of people who are terminally ill should be available. The failure to link education to clinical practice and clinical outcomes was proposed by them to represent a major limitation in nursing knowledge. Care of the terminally ill patient requires not only possessing the necessary knowledge and skills in the area, but it is also essential to be able to provide competent psychological care (Blackburn, 1989).

Copp (1994) examined the results of different studies to explore the effect of educational courses on nurses who were caring for people who are terminally ill. For example Game and Pringle (cited in Copp, 1994, p.553)

suggested that previously training excluded education concerning death, and Field and Kitson (1986) found that although the topics of death and dying were included in the curriculum for training, very few hours were actually allocated to them. Many studies focused on two areas: firstly, acquiring information about whether death and dying was being taught as part of the nursing curriculum; and secondly, questioning nurses about their experience with dying patients. A study by Quint (1967) on the education of nurses with dying patients noted the lack of education for nurses in this area of specialised care. He discussed that a more methodical approach to training nurses in death and dying was needed, which could be supported by experience in a clinical environment.

Birch (cited in Copp, 1994, p.553) also found that there was insufficient preparation of nurses to care for people who are terminally ill. Either no instruction was received by the nurses during their training or insufficient time was given to this area. Copp (1994) discussed a group of nursing students who undertook practical training in a Loss, Adjustment and Dying unit. Through the use of reflection on their work they were able to learn about themselves and discuss personal situations which they had experienced. This method allowed these students to develop their own knowledge about practice through the learning experience. Although Copp has reviewed studies and proposed that the needs of dying patients and their families need to be identified, much of the article was descriptive and further

research needs to be conducted in order to critically identify many of these areas.

This approach was supported by Kinzel, Askew and Godbole (1992) who reported that there was no specific information regarding physicians' or nurses' attitudes toward, and knowledge about hospice care. They suggested that the type of care that people who are terminally ill were likely to receive was dependent on the knowledge and attitudes of the nurses and doctors attending them. Adams (1984) reported that only anecdotal reports of physicians' attitudes towards the treatment of cancer patients existed.

Kinzel, Askew and Godbole (1992) undertook a study to examine the knowledge and attitudes of hospital based physicians and nurses to palliative care. The instrument in this study should be viewed with caution, as no reliability or validity data was reported. The participants worked in a rural medical centre where a palliative care program with a registered nurse as coordinator had been operating for two years. The results indicated that 48% of nurses and 49% of physicians were satisfied when caring for a person who was terminally ill, 76% of nurses and 87% of physicians found palliative care useful in caring for people who are terminally ill, and 92% of nurses and 88% of physicians were secure in their ability to provide competent, high quality care to people who are terminally ill. Physicians indicated a better knowledge base than nurses with regard to pharmacological therapeutics while the positive attitudes of both nurses and physicians did not correlate with the

knowledge and skills required to provide adequate palliative care. Lack (1984) indicated that this discrepancy between the attitude and knowledge may be due to "an inability to recognise or acknowledge the qualitative and quantitative difference between curative therapy and symptom control in terminally ill patients" (p.33).

As has been stated above, the palliative care literature emphasises the role of knowledge needed by nurses and other professionals to develop their capabilities to practice palliative care. In their work with the Victorian Order of Nurses (VON), Dunne and Falkenhagen (1988) identified a lack of a continuing higher education by nurses to develop their abilities. VON now supports the idea of a multidisciplinary and specialised palliative care team to provide palliative care to patients. In order to achieve this all nurses wishing to be part of the team, needed to indicate a high level of professional practice. Through weekly seminars and workshops, nurses developed their knowledge and skills to provide optimum symptom control and management and developed specialised techniques for the care of their patients (Dunne & Falkenhagen). Whilst caring for people who are terminally ill can be rewarding for nurses, it can also be stressful; therefore peer support is available to encourage sharing of information and concerns which help reduce stress. The model suggested in this study is where VON nurses are part of a specialised team to provide palliative care to terminally ill patients in the community. This model has ensured that the nurses are well prepared and

competent to provide palliative care services. Dunne and Falkenhagen concluded that staff with the necessary knowledge and skills were vital to provide high quality palliative care services.

However, Benoliel (1983) and Degner and Gow (1988) have suggested that previous studies were contradictory in their results on whether education has reduced the level of concern in nurses after education courses on the topic. Copp (1994) has indicated that there was no evidence to suggest significant relationships between topics that the nurses were taught and problems they experienced when caring for the terminally ill. A change in attitudes may occur not only through educational means, but through situations where nurses are able to discuss their difficulties and share their problems, concerns and distress with other groups of nurses.

Benner and Tanner (1987) distinguished between "know that" and "know how" knowledge. Very often "know how" knowledge was not taken into account, and more emphasis placed on the rigid, scientific knowledge. Copp suggested that this experience accumulated by nurses working in the area needed to be channelled to help the more inexperienced nurses. She suggested that in the future, nurses being trained in the palliative care area, required more practical knowledge, and the role of "know how" knowledge had to be recognised. However, the precise contribution made by education to nurses' behaviour and attitudes was unclear (Benoliel, 1983). Benoliel suggested a need to review nurses' concerns about other points, such as

cultural differences in death, educational practices and the exposure of the nurse to death.

Currently there has been little progress in identifying other areas besides knowledge and skills that may predict nurses' attitudes to palliative care. A study by Kinzel, Askew and Godbole (1992) indicated that nurses have a greater involvement with the daily care of the patient and a closer share of the patients' experiences within the palliative care setting than the attending doctors. They suggested that the physicians may be more committed to providing information and therapeutics, while the nurse was more involved with daily care of the patient.

Martocchio (1987) indicated that nurses as professionals cannot be separated from the personal emotions and feelings that they may feel. These emotions or feelings of nurses have, in the main, been ignored by the literature (Martocchio). Hurtig and Stewin (1990) suggested that feelings of denial and anxiety by the nurse should not be dismissed. However, the measurement scales available to access these feelings were often difficult to interpret. The authors examined the death attitude measurement scales, and concluded that many terms had been used to measure, supposedly, the same construct, for example, "death fear", "death anxiety", "death concern", "death acceptance" and "reconciliation with death".

Benoliel (1988) offered an alternative view, suggesting that besides what nurses learnt in their training, it was their clinical experience which

would influence their attitudes towards palliative care. She commented that the main problem has been the lack of teaching about death and dying in medical and nursing schools, as well as little formal teaching about palliative care principles and practices to medical and nursing students. There is emphasis on the biomedical model and the tendency to have a health care system which engages in lifesaving activity, without acknowledging the patients' suffering and dying. With this type of training, these values become integrated into the value system of nurses and medical students. She further commented that palliative care is an attitude towards caring for a person who is terminally ill, as much as it is about learning the technical knowledge of how to care for these patients. In their education, nurses and physicians have not learnt how to be part of a multidisciplinary team and work with people specialised in different disciplines.

Degner, Gow and Thompson (1991) identified critical nursing requirements in caring for the dying in an exploratory study with 10 experienced nursing educators and 10 experienced palliative care nurses as participants. The participants were asked to describe the behaviours they considered to be associated with negative and positive attitudes to caring for people who are terminally ill. The researchers identified essential behaviours of the nurses in caring for people who are terminally ill.

The authors also examined the literature to identify critical nursing behaviours for those nurses who care for people who are terminally ill

identifying comfort care of the patient with specific emphasis on pain control, talking with the patient about feelings with respect to dying, supporting colleagues, respecting patients' rights and family care. A major difficulty was the uncertain and imprecise way in which these behaviours were detailed in the literature. There was a difference between the behaviours identified by the nurses and those found in the literature, anger and enhancing personal growth being included by the nurses.

Degner, Gow and Thompson (1991) suggested that these behaviours identified by the nurses could be used to begin structuring an education program and guidelines for nurses. Other clinical settings also needed to be identified. These behaviours could then form the basis of a future model to identify critical nursing behaviours in caring for people who are terminally ill.

In support of examining a variety of nursing behaviours, McWilliam, Burdock and Wamsley (1993) examined the experiences of nurses as part of a multidisciplinary team working in palliative care which provided home support and coordination services to patients with cancer, discharged from any one of three large hospitals which provided acute care.

The researcher examined goals given by nurses and their needs, motives, expectations, work effort and obstacles stated in interviews. The findings indicated that the nurses were concerned with preserving their own integrity and continually reflected on their professional practice base. The nurses commented that they were continually dealing with their own conflict

in terms of issues such as losing control, personal losses, euthanasia and feelings of inadequacy in dealing with the diverse range of complex problems associated with people who are terminally ill, such as psychosocial care problems. The authors commented that any genuine relationship that the clinician develops with patients and their family will involve suffering on different levels on the part of the clinician. They also stated that the nurses needed to address their own personal distress, and that which is experienced in support of the patient.

The results of this study raise questions regarding the education and care of nurses who care for people who are terminally ill. McWilliam, Burdock and Wamsley (1993) suggested that these nurses may benefit from help aimed at nurses' understanding their own professional needs, motives and expectations from this type of work. Furthermore they may gain from personal and professional conflict management and assistance in learning how to work as a member of a team.

As palliative care is practised by nurses, the kind of care that the terminally ill receive in nursing homes is influenced by the attitudes of the nursing and medical staff (Kinzel, Askew & Godbole, 1992). Insight into these attitudes of nurses to palliative care has emerged as a way of establishing, maintaining and improving palliative care services. The following chapter examines attitudes.

CHAPTER 2

Research on Attitudes

2.1 History of attitude theory

The importance of attitudes and attitude change has been recognised over time and has long been of interest to social psychologists (Olson & Zanna, 1993). The area is characterised by an absence of one main theory that has been proposed on attitudes (Eagly, 1992), yet the term "attitude" has been regarded as indispensable when attempting to understand concepts in different areas such as in social groups or social policies as well as in the political arena. Many different perspectives on attitude theory have been suggested with researchers subscribing to various viewpoints at different times.

The study of attitudes within social psychological research has emerged as a dominant area of attention at three separate phases, each time pursuing a different area of focus within the domain (McGuire, 1986). The first phase started during the 1920s when attitude theory started to flourish in the area of attitude measurement. This period included theorists such as Thurstone and Chave (1929) who developed equal appearing interval scales; Saffir (1937) who developed successive intervals; and Likert (cited in McGuire, 1986,

p. 91) who developed a method of summated ratings in 1932, as he believed Thurstone's scaling methods were too difficult and complex. McGuire (1986) believed that this first period came to an end because the emphasis placed on definitions and the meaning of terms within the area resulted in an uncertainty concerning the areas in which attitude theory may be applied, and this resulted in a focus on measurement techniques by theorists.

The second phase which was concerned with attitude theory occurred during the 1950s and 1960s, with an emphasis on attitude change. At the beginning of this period, prominent issues such as primacy and recency and racial prejudice were addressed by theorists such as Hovland, Campbell and Janis (McGuire, 1983). McGuire (1986) indicated that during the 1960s attitude theory was examined from different viewpoints such as dissonance theory (Festinger), psychoanalytic theory (Katz) and perceptual perspectives (Sherif).

Subsequently, interest subsided in the attitude area. During this period, however, sporadic research did appear. For example, attribution theory, which was based on Heider (1958), examined how the individual interpreted the world and reacted to this interpretation (McGuire, 1986). Although most of the theories of the time incorporated some attitudinal constructs, they were mainly involved in cognition and social behaviour (Eagly, 1992). It was this work on cognitive processing and person perception research that directly influenced the next stage on attitude structure (McGuire, 1986).

This third stage started in the 1980s and continues to the present time, with the major emphasis being on attitude structure (McGuire, 1986).

McGuire proposed that in this phase, researchers were starting to focus on the structure of attitudes on three levels:

1. The structure of individual attitudes.
2. The structure within systems of attitudes.
3. The structure of attitudes within the individual.

The structure of individual attitudes has concentrated on looking at the relationship between cognitive, affective and behavioural components of the attitude as well as the expectancy-value models (Ajzen & Fishbein, 1980; Fishbein, 1980) which have been beneficial for predicting behaviour.

McGuire concluded that the current style of research tends to examine the interrelationship between variables in the world as it exists today rather than looking only at distinct components of the system.

2.2 The importance of attitudes

The fundamental importance of the domain of attitudes was illustrated by Allport in 1935 that "the concept of attitude is probably the most distinctive and indispensable concept in contemporary American social psychology" (p.198). Even though interest in the area has wavered over time (McGuire, 1985,1986), the concept of attitudes has continued to receive attention.

There have been many reasons for examining attitudes, yet over the years Johnson (1991) reports that interest in the attitude - behaviour link was a main incentive for social psychologists to study attitudinal constructs. In earlier years, very little research examined the implications and the significance of an attitude to an individual and how a particular attitude impacted on the life of that person. Kraus (1995) suggests that the attitude construct may be useful for social psychologists to study the reasons for certain types of behaviour. Further, areas such as information processing, social influence and individual differences can be examined through the attitude domain because attitude measures have become more reliable, readily accessible to devise and conduct, and better sampling techniques have led to more representative samples being chosen (Kraus, 1995).

Further reasons for the importance of attitudes were described by earlier researchers (Smith, Bruner & White, 1956; Katz, 1960) who suggested that attitudes may be useful when trying to assess the value of certain objects or constructs to people, as well as serving a knowledge function, whereby a person's attitude may be used as a source of information. However, Jamieson and Zanna (1989) suggested that attitudes may be most valuable in helping to understand the way in which individuals try to achieve clarity, structure and consistency in their world and may form the basis of this desire and aid in its explanation.

2.3 Definitions and conceptualisations of attitudes

Although the attitude domain has been popular at different times there has never been acceptance of a single definition of an attitude. Pratkanis (1989) reported that varied connotations of the term "attitude" have been proposed over time. Historically attitudes have been explained in terms of muscular preparedness, adaptedness, cognitive set, dynamic motivation and mental processes. Allport (1935) put forward one of the earlier definitions of attitude which implied that attitudes are learned. Ostrom (1989) suggested that this definition considered an attitude as a state of readiness which had a powerful control over the responses of the individual. Ostrom concluded that Allport used the term, attitude, to depict any psychological state to which an individual may respond.

Alternatively, Thurstone (cited in Ostrom, 1989, p.12) examined attitudes by taking into account three different aspects of the attitude. He was interested in features of the attitude construct, the characteristics of the continuum along which the attitudes or attitudinal statements would be found, and the relationship between an individual's personal responses and the responses that an individual actually exhibited. As Thurstone was mainly concerned with an individual's personal responses, he considered these responses as being comprised of a "person's beliefs and thoughts about an attitude object, their affective feelings about the object, and their past actions and future intentions toward the object"(cited in Ostrom, 1989, p. 13).

Thurstone suggested a view (cited in Zanna and Rempel, 1988, p.316) that attitudes comprised evaluative responses to attitude objects; therefore each individual's response could be found on a point along this evaluative dimension. An attitude object in his or her terms may be anything that one is able to evaluate. Allport considered this emphasis on the evaluative dimension as being too simplistic of the attitude construct (Ostrom, 1989). Ostrom further suggested that it was not that Allport was opposed to this concept of an evaluative dimension, it was that he thought it too trivial and not representative of the more complex states of readiness that he considered the basis of the attitude construct. Furthermore, Allport never referred to an attitude object within his definitions on attitude, whereas Thurstone considered that all attitudes must be in response to an attitude object. As Ostrom argued, the main reason that Allport chose not to use the concept of attitude objects was because it would have been problematic to assign attitude objects to all the types of attitudes that Allport had identified, such as emotional attitudes and complacent attitudes.

Other theorists have approached the attitude construct differently. For example, Fishbein and Ajzen (1975), in a more recent version of the theory originally put forward by Thurstone, proposed that cognition was responsible for affective responses, and in their theory of reasoned action, they considered attitude synonymous with affect. On the other hand, Campbell (1963) referred to attitude as an acquired behavioural disposition, with concept, habit and

schema as examples of such acquired behavioural dispositions (Eagly & Chaiken, 1993). However, as Eagly & Chaiken suggested, the term "disposition" has an enduring connotation which may be used to describe a type of personality, but is inappropriate for use in a definition of attitude, as attitudes may be temporary. Another example to illustrate the variety of attitude definitions is one put forward by Petty and Cacioppo (1981) who define attitude as "a general and enduring positive feeling about some person, object, or issue" (p.7). It is important to note that most of the above definitions imply an evaluation (e.g., good and bad), with Petty and Cacioppo's (1981) definition suggesting an emotional component of the attitude.

The evidence for the distinction between affect and evaluation, as distinct components of the attitude, has been varied, with most studies producing very high correlations between the two constructs. In a study in 1984, Breckler validated the separate use of the three components and examined the attitudes of participants towards snakes. His findings support the idea that affect and evaluation are distinct entities in the structure of attitudes and that the unique contribution of each, needs to be established.

Currently most theorists tend to define attitude in terms of an evaluation (Olson and Zanna, 1993). For example, Eagly and Chaiken (1993) define attitude as "a psychological tendency that is expressed by evaluating a particular entity with some degree of favour or disfavour". The entity referred

to in this definition is the same as the attitude object referred to above. Eagly (1992) suggested that the idea of an attitude as an evaluation has been agreed upon over a period of time among different researchers (e.g., Allport, 1935; Campbell, 1963; McGuire, 1969; Zanna and Rempel, 1988; Ostrom, 1989).

Within many established definitions of the term "attitudes", the concept that attitudes are evaluations has been omitted from the definition. Eagly & Chaiken (1993) suggested that an attitude develops only when an individual considers the evaluation of an attitude object and responds to that evaluation. Attitude objects can be defined as anything "that is discriminated or that becomes in some sense an object of thought can serve as an attitude object" (p. 5). An evaluation of the attitude may be bipolar and vary from positive to negative, with points in between and a neutral point in the middle (Ostrom, 1989). Eagly & Chaiken (1993) indicated that the evaluation has both intensity and extremity. So for example, one individual may have a strongly negative evaluation as opposed to another who has a moderately negative evaluation to the same attitude object.

The preceding discussion emphasises the complexity which has been prevalent within this area. Many alternative models and definitions have been proposed, each with its own system to describe attitudes. It is the evaluative dimension that currently receives much attention in the literature. The structure of the attitude needs to be examined in view of the different definitions of attitudes that have been put forward.

2.4 The structure of attitudes

In the attitude domain, there have traditionally been two major viewpoints proposed on the structure of attitudes, namely that attitudes are unidimensional or attitudes are multidimensional. Within the unidimensional approach, attitudes are regarded as affective responses toward attitude objects. For example, Thurstone (cited by Zanna and Rempel, 1988, p.316) suggested a view that attitudes comprise evaluative or affective responses to attitude objects. Fishbein and Ajzen (1975) in a more recent version of this theory proposed that an attitude is "a learned predisposition to respond in a consistently favourable or unfavourable manner with respect to a given object" (p.6). They considered that cognition was responsible for affective responses. Other definitions, such as that proposed by Petty and Cacioppo (1981) regarded an attitude as a lasting emotion, which can be positive or negative, towards an individual, object or any other matter. Breckler and Wiggins (1989) distinguished three main factors associated with these definitions, namely, that attitudes are learned, that they encourage action, and that they suggest evaluation.

Instead of considering the attitude only as an affective response, a multidimensional view, put forward by researchers Katz and Stotland (1959), Rosenberg and Hovland (1960), stated that such an evaluation can be divided into three classes; cognitive, affective and behavioural. This differentiation

into cognition, affect and behaviour is not new. Hilgard (1980) reported that this classification of actions into cognition, affection and conation (policy orientation) was found in Germany in the eighteenth century and was later adopted in the nineteenth century in Scotland and England by scholars such as Sir William Hamilton (1788 - 1856) and Alexander Bain (1818 - 1903).

Hilgard (1980) further suggested that the founders of modern psychology did not ignore this classification into three areas, but rather chose to express it in their own terms. For example, Warren (cited by Hilgard, 1980, p. 113) in 1906 referred to external, systematic and kinaesthetic senses instead of cognitive, affective and conative characteristics. McDougall (cited by Hilgard, 1980, p. 114) in his book Social Psychology in 1908 which discussed instinct psychology, indicated that he remained committed to the familiar classification of mental activities into the three components. He assumed that everyone was familiar with the division into cognitive, affective and conative components as it was "common sensical and noncontroversial".

Support for this tripartite classification appears to have waned after McDougall. Allport (cited in Hilgard, 1980, p. 114) suggested that the decline for support was because there was no need for such a general and all embracing view of mental processes. Yet this classification, perhaps because of its usefulness, has been frequently used in psychology especially by social psychologists in the attitude area (e.g., McDougall, 1908; Bogardus, 1920,1925; Campbell, 1947; Krech & Crutchfield, 1948).

2.4.1 Tripartite model of attitudes

Although this trichotomy has long been in existence, it was not until the late 1940s that the tripartite or three component view on attitudes was articulated when Smith (cited in Breckler, 1984, p.1192) proposed differences between affective, cognitive and conative (policy orientation) aspects of attitude. Yet it was only by 1960 that this model became widely accepted in attitude theory (Breckler, 1984).

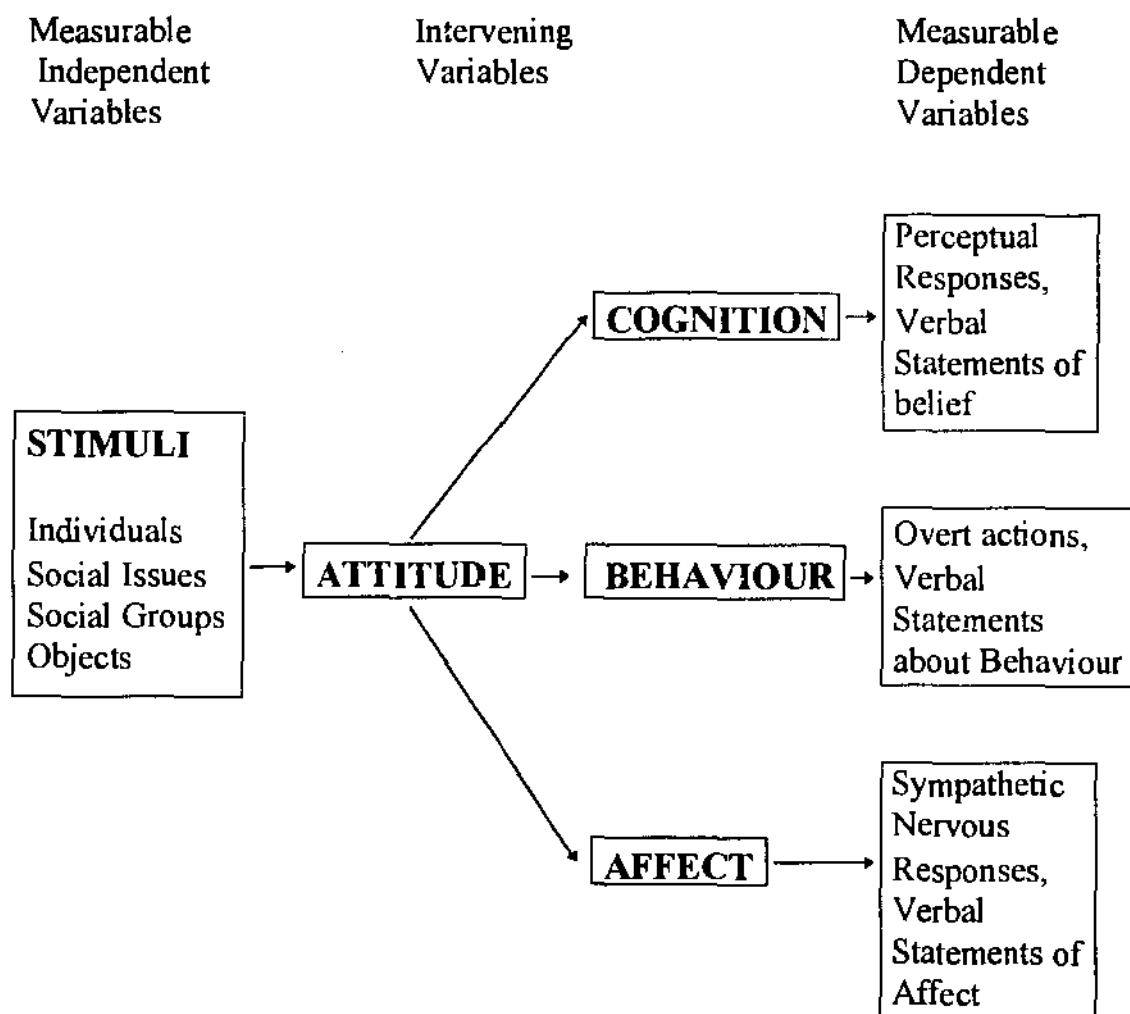


Figure 2.1. The tripartite model of attitude structure according to Rosenberg and Hovland (1960, p.3).

Rosenberg and Hovland (1960) proposed a tripartite model of attitudes in which they suggested that stimuli were responsible for different responses that were produced by the individual, as well as different types of responses which were then demonstrated by the individual (see Figure 2.1). These different types of responses could then be measured as indicative of the attitude, and consisted of three main categories, namely, cognitive, affective and behavioural components (see Figure 2.1), which suggests a multicomponent structure to attitudes (Hills, 1994). In this model Rosenberg and Hovland (1960) indicate that attitudes are "predispositions to respond to some class of stimuli with certain classes of responses and designate the three major types of responses as cognitive, affective, and behavioral" (p. 3).

The way in which these classes were measured is indicated on the right hand side of the model; therefore the three classes of information are inferred from these measurements taken on the right hand side of the model. For example, the affective response of an individual towards another individual would be measured by physiological means such as blood pressure or galvanic skin response, in addition to verbal statements of how much the person likes or dislikes the other individual.

Rosenberg and Hovland (1960) described that the behaviour may be evaluated by the way he or she responds to the situation or it may be inferred from how the individual says he or she will behave in a given situation. Cognitions incorporate beliefs, concepts and perceptions that the individual

possesses about the attitude object, and are measured by verbal questions in a printed or oral format. One of their main aims in formulating this model was to examine the internal organisation of attitudes, and its relationship to attitude change.

Previous research into each of the three components was primarily concerned with affect to the exclusion of investigating the other attitude components (Ostrom, 1968). For example, the measurement techniques developed by Thurstone and Chave (1929) were concerned with the evaluation of the individual's feeling about the attitude object. Krech and Crutchfield (1948) also considered feelings as being central to the decision of whether an individual was "for or against" an object or issue. In spite of its success and apparent acceptance by many social psychologists, criticism has been levelled at the model.

1. There has been criticism in terms of the supposed relationship between the three components, with the attitude-behaviour relationship responsible for most of the controversy (Zanna and Rempel, 1988; Greenwald, 1989).
2. Many studies have been unable to validate the connection between the affective component of the model and physiological responses which were used to measure this component (Breckler, 1984).
3. Cacioppo, Petty and Geen (1989) suggest that these physiological responses need not be confined to the affective component, but may also provide information about the cognitive and behavioural components.

However, Cacioppo, Petty and Geen (1989) conclude that the tripartite model of cognition, affect and behaviour is central to the attitude concept, and that the relationship between each of the components of the tripartite model and the attitude of an individual to an attitude object is a valuable function.

In the unidimensional view of attitude, the attitude or evaluation is equivalent to affect (e.g., Ajzen & Fishbein, 1980), as compared to the multicomponent view (of which the tripartite model is an example), which considers cognition, affect and behaviour. In other unicomponent views, researchers have emphasised either the cognition, affect or behavioural component. By adopting the tripartite model and using all three components, the relationship between attitude and behaviour remains unsubstantiated (Wicker, 1969).

The cognitive dimension includes thoughts and beliefs that individuals may have about the attitude object. As Eagly & Chaiken (1993) suggest, this category may also include knowledge, opinions, information and inferences. The affective component encompasses the feelings or emotions of the person with respect to the attitude object. For example one might have strong emotions towards the issue of driftnet fishing, but have no feelings towards a fishing rod. The behavioural component is concerned with the individual's actions or behaviour towards the attitude object. It may also include their intention to act. For example if one dislikes cats, one may have the intention

of shooing a cat away every time one appears. This action may or may not be carried out in practice.

There are some researchers (e.g., Greenwald, 1968) who considered that the three components may differ from each other, depending on the basis from which they arise (Zanna & Rempel, 1988). Breckler (1984) agreed that the three elements do have some degree of correlation. In supporting Breckler, Greenwald (cited in Breckler, 1984, p. 1193) suggested that the precursors of cognition, affect and behaviour may be based on the same learning situation. If they are founded on different learning situations, high correlations between the three elements may not appear. Zajonc (1980) argued that whether the basic learning situation was similar or dissimilar, the way the three components contributed to the attitude may be different. He suggested that affect and cognition were regulated by separate and "partially independent systems" (p. 151) which may have a bearing on each other, but may also be quite independent of each other. This indicates that the components could operate independently or in cooperation with each other.

The role of affect has been examined by Zajonc (1980) who proposed that an individual may like an object before being aware of and without knowing what it is. In trying to remember, recognise or retrieve an event, an experience, a person, or a piece of music, it may be the affective information of the original experience which first becomes obvious. Even if this affective reaction is ill defined and unclear, it may still influence any further cognitive

processes which may occur. Zajonc further stated that new emotions may emerge to the object, such as a person or a piece of music, after cognitive activity has been initiated. Emotions and feelings may be a part of cognitive activity, although this does again partly arise from a "parallel, separate, and partly independent system in the organism" (p.154).

Zajonc (1980) provided empirical evidence to show that affect may be independent of and even precede some cognitive activities. His main conclusion was that the components, cognition, affect and behaviour could operate independently or in cooperation with each other.

2.4.2 Evidence concerning the tripartite model

Most of the research undertaken, has examined the relationship between pairs of the classes of information (Breckler, 1984), for example between affect and cognition (Rosenberg, 1956) or has tried to determine the correlations within the measures of cognition, affect and behaviour (Triandis, 1967). Other studies (e.g., Ostrom, 1969; Kothandapani, 1971) have used all three measures of cognitive, affective and behavioural components. Ostrom (1969) for example, obtained four verbal measures of each attitude component using attitude towards the attitude object, namely, the church. Ostrom tried to establish whether each of the components, cognitive, affective and behavioural, was unique and could predict the attitude in its own right. The results indicated that each of the three components was independent and

distinct. The results were reliable although the magnitude was small.

Furthermore, only one attitude object was used (Bagozzi, 1978).

Kothandapani (1971) used a similar procedure to Ostrom with birth control as the attitude object. The study investigated two groups who were users and nonusers of contraceptives. These studies have since been subjected to further statistical analysis by Bagozzi (1978) and Breckler (1984). Both analyses indicated that Ostrom's data provided unsubstantial support for the tripartite model, while Kothandapani's (1971) data provided support for a unidimensional model and rejected the tripartite model.

Breckler (1984) suggested that the difficulty with the above research was that it depended only on verbal responses to the three classes of information. He then validated the tripartite model using verbal and nonverbal measures to show that cognition, affect and behaviour were distinct components of attitude. Subjects' attitudes towards snakes were examined in the presence of a live, caged snake. Nonverbal measures of affect and behaviour were used. He found that the correlations between cognition, affect and behaviour were moderate ranging from .38 to .71 and argued for the value of distinguishing them from each other.

In a second study, Breckler (1984) used verbal reports and the participants were asked to imagine that a live snake was present. The results from this study indicated that the components were more highly correlated than in the first study, demonstrating that the use of verbal report measures

was important in producing high intercomponent correlations. Breckler (1984) hypothesised this in terms of experience, as one became more familiar with an attitude object, there should be more consistency among the components. High intercomponent correlations were likely to exist when subjects have had past experience with the attitude object such as the church in Ostrom's (1969) study, whereas low intercomponent correlations were likely to occur if subjects have had little prior experience with the attitude object.

Other research has emerged which considered the different components and their relationship to the overall evaluation of the attitude. Zajonc (1980) examined the role of the affective element to the evaluation of the attitude. Subjects were presented with random polygons and asked to rate them for "liking" after which their recognition memory was tested. His results indicated that liking judgements were made with more confidence, and that affective judgements of polygons were made faster than recognition judgements. Zajonc concluded that some system existed whereby subjects were able to experience affects towards the polygons without using cognitive activity in recognition memory tests.

A further study by Eagly, Mladinic and Otto (1994) examined whether the feelings and emotions of the participants provided any extra information about the attitude object after beliefs had been accounted for. Two experimental conditions were used, the first examined attitudes towards four social groups (women, men, Democrats and Republicans), the second

examined attitudes towards three social policies (abortion on demand, affirmative action in employment and welfare assistance for the poor). In order to overcome problems of using checklists, participants were required to report beliefs and affects that "come to mind" (p.118) with respect to the attitude object. In the first experiment, beliefs were the only significant predictor of attitude to women, men and Democrats, whereas for Republicans beliefs and affects both significantly predicted attitude.

In experiment 2, results indicated that affect was a slightly better predictor of attitude in two of the three social issues that Eagly et al. (1994) canvassed. Although affective responses were important to prediction of the attitude, cognitive responses remained more important. Although these results were modest, they were significant as they suggested that feelings and emotions, as well as beliefs, may contribute to the overall evaluation of the attitude.

In support of emotions and feelings contributing to the overall evaluation of the attitude after beliefs had been explained, Abelson, Kinder, Peters and Fiske (1982), carried out two national surveys in which participants were required to assign personality traits to well-known politicians and check their feelings towards the politicians. Their results indicated that the feelings which the candidates generated within the participants affected how favourably the candidates were evaluated. They found that good feelings and bad feelings were nearly independent of each other, and that affect scores were

strongly predictive of the evaluation of the candidate. Although the findings of Eagly, Mladinic and Otto (1994) did not support Abelson et al. (1982) in that affect may be a better predictor of attitude, they did establish that affect makes a contribution to the overall evaluation of the attitude.

In the past, researchers such as McGuire (1968) have suggested that the two components, affect and cognition, were too highly correlated to enable researchers to distinguish between them. Other studies (Ostrom, 1969; Bagozzi, 1978; Breckler, 1984; Breckler & Wiggins, 1989; Edwards, 1990) however, have maintained the idea that affect and cognition should be considered as separate components in the evaluation of the attitude. For example Breckler and Wiggins (1989) examined the distinction between affect and evaluation where evaluation incorporated thoughts, beliefs and judgements about an attitude object. The correlation between affect and evaluation (cognition) varied from .25 to .89 which supported maintaining affect and cognition separately. Breckler and Wiggins (1989) suggested that if affect and cognition are to be regarded as separate components, then different measurement scales would be required to assess each individually. Secondly, each component may be linked to a specific attitude function. Thirdly, affect and evaluation may influence behaviour in different ways.

As the literature lends support to the concept of the multicomponent view of attitudes, different examples have been proposed using this theory. One such model is that proposed by Zanna and Rempel (1988) which

considers the three classes of information, namely: cognitive, affective and behavioural information, as "correlates of the attitudes" (p. 120). This model has attempted to integrate different views on attitude formation, and considers that the cognitive, affective and behavioural information determine the attitude through different psychological processes (Chaiken & Stangor, 1987).

Although this model needs to be tested and refined using different attitude objects to establish the relationship between these three classes of information of cognition, affect and behaviour and the way they influence the attitude, the model has theoretical implications in considering different aspects of attitudes such as attitude ambivalence (Chaiken & Stangor, 1987). The model provides a useful framework to examine the antecedents and consequences of attitudes, as not all three classes of information will apply to every attitude (Olson and Zanna, 1993).

2.4.3 Model proposed by Zanna and Rempel (1988)

Zanna and Rempel (1988) use the tripartite model as the foundation for their definition of attitudes. Noting that attitude theory has previously made use of the tripartite model, they recommend this model as a standard for future study. By making use of the tripartite model, former theories and research in the attitude domain can form part of this present model. They define attitude as "the categorisation of a stimulus object along an evaluative dimension based upon, or generated from, three classes of information: (1) cognitive

information, (2) affective or emotional information, and/or (3) information concerning past behaviours or behavioural intentions" (p.319). They proposed that these three different components can influence the attitude either separately or together and be possible contributors to a specific type of attitude. They further suggested that it was not necessary to measure all three components to determine the attitude. The model is shown in Figure 2.2.

The evaluation of the attitude object refers to the estimation that an individual places on one attitude object as compared to another. In order to measure this construct, categories are put at each end of the continuum. Zanna and Rempel (1988) proposed that a minimum of two categories should be used, such as "good and bad", or "better than and worse than". An example of this scale is illustrated in Figure 2.3.

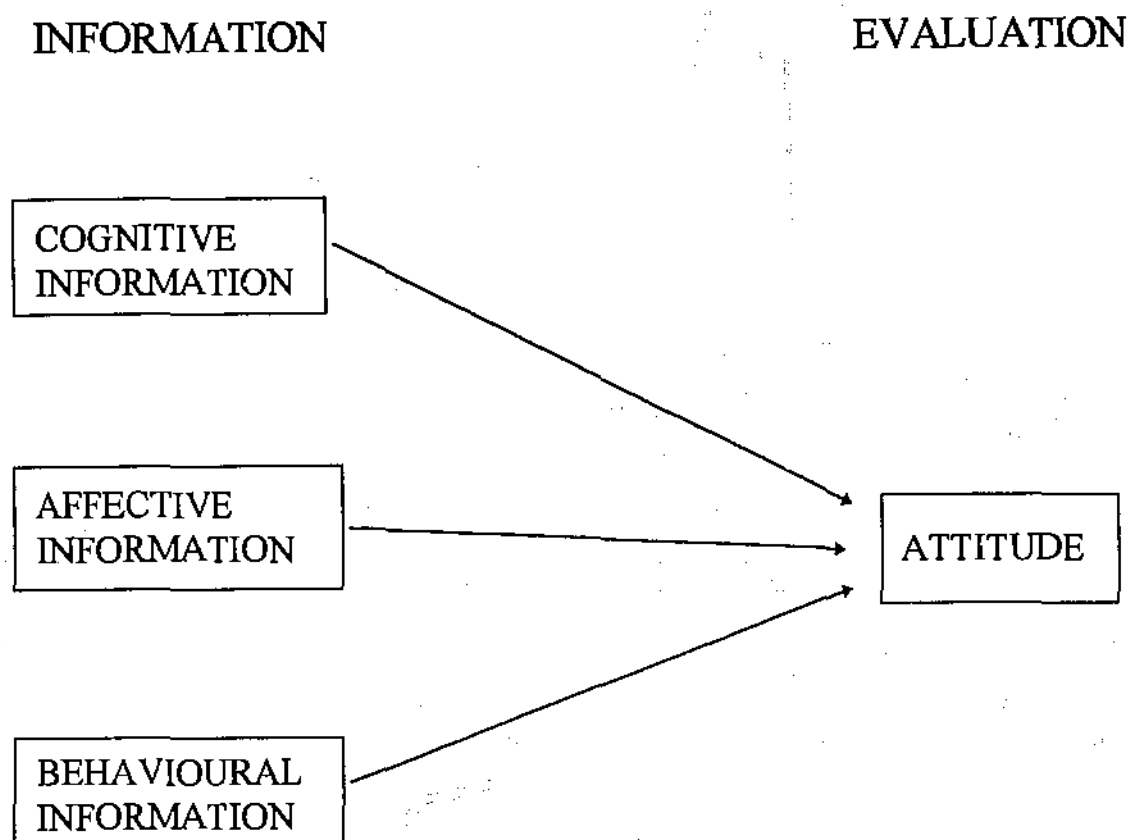


Figure 2.2 Tripartite model of attitudes proposed by Zanna and Rempel (1988).

Attitude object (e.g., Cats)

Good	1	②	3	4	5	6	7	Bad
Favourable	1	2	3	④	5	6	7	Unfavourable
Dirty	1	2	3	4	⑤	6	7	Clean
Pleasant	1	2	③	4	5	6	7	Unpleasant

Figure 2.3 An example of semantic differential bipolar scales

Note that Zanna and Rempel (1988) define the attitude as “the *categorisation* of a stimulus object”. The term “categorisation” implies that some cognitive function takes place, as the attitude object needs to be distinguished and internalised before any evaluation of its significance can be made. Zanna and Rempel stressed that although noncognitive input may be fundamental to the attitude, evaluation itself does require some cognitive activity. By using the term cognition, they suggested that this implied that attitudes were “items of knowledge”. However it is important that one does not exclude the way the attitude was experienced.

They commented that although the attitude may be based on beliefs, emotions or the previous behaviour of the individual with the attitude object, all of these may impinge on the formation of the attitude. They suggested therefore, that the beliefs, emotions and behaviours of the individual represented distinct methods in the formation of the attitude and how it then occurs.

There are important implications for attitude theory in adopting this definition proposed by Zanna and Rempel (1988), who suggested that the formation of the attitude, that is, the evaluation of the attitude object, may be founded on different types of information. If this is so, then an individual may have different attitudes to the same attitude object. For example, in considering cats, whereas one person may have a negative attitude towards these cats and dislike them as pets and not consider them to be loyal, the same

person may have a positive attitude towards some cats if they look very fluffy and cuddly. Furthermore, Zanna and Rempel proposed that the basis of an attitude has an important role in the stability of the attitude, so that an attitude based on one class of information may be far more stable than an attitude based on another class of information. One may again consider the example of cats. The attitude that is based on the belief that cats make disloyal pets may be far more enduring than the positive attitude that a cat is cute and cuddly. It is important to note that Zanna and Rempel do not regard affect and evaluation as being synonymous. Feelings and emotions may be responsible for the formation of the attitude, but they are not the same as the attitude itself.

In adopting this model, one may integrate previous theories on attitude to examine attitude formation. For example, Zanna and Rempel (1988) commented that if the attitude was dependent on the beliefs held by the individual, then the expectancy-value theory proposed by Fishbein and Ajzen (1975) may account for the complicated and reasoned attitude formation. If the evaluation was dependent only on the feelings or emotions of the individual, then affect as proposed by Zajonc (1980) may contribute to the attitude formation. Bem's (1972) theory of self-perception may be applied if the evaluation of the attitude object is dependent on the past behaviour of the individual. Therefore as Chaiken and Stangor (1987) suggested, the model proposed by Zanna and Rempel (1988) is an attempt to integrate different views of attitude formation.

In their model, Zanna and Rempel (1988) used the term cognitive information to describe beliefs and items of knowledge. They also use the term "affect" to denote experienced emotions or feelings. The term, "behaviour" is used to refer to the way a person has dealt with the attitude object previously or the way they intend to behave towards it. Zanna and Rempel (1988) suggested one needs to determine which source of information better predicts the attitude to a particular attitude object - cognitive, affective or behavioural. They also recommended that the class of information responsible for the attitude needed to be tested in different domains, as different classes of information may be responsible for the attitude according to the area.

This model requires that evaluation be measured separately from the other sources of information. The authors further suggest that not all three classes of information are necessary and that the attitude may be based on one or a combination of the different classes of information. The efficacy of the attitude model proposed by Zanna and Rempel (1988) could be validated through studying attitudes to different attitude objects. They argued that little research has investigated whether the prediction of attitudes can be improved by looking at the different classes of information. Abelson, Kinder, Peters and Fiske, (1982) and Eagly, Mladinic and Otto, (1994) have considered the role of affect in the formation of the attitude and it was the methodological issues in some of these studies that have raised questions concerning their results

(Eagly, Mladinic & Otto, 1994). These methodological issues are discussed in section 2.6. Before proceeding to this discussion of methodology, however, it will be useful to consider one final aspect of attitudes - that which concerns attitudinal knowledge structure.

2.5 Attitudinal knowledge structure

Zanna and Rempel (1988) referred to attitudes as "items of knowledge in the form of evaluative summations" (p.330) with the intention that this definition will aid the understanding of social knowledge. They suggested that cognition alone cannot account for the foundation and familiarity of knowledge. However, the attitude judgement may be made solely on the basis of factual beliefs, or it may have an emotional basis, or it may depend on the previous behaviour of the individual with the attitude object. Zanna and Rempel (1988) suggested that it may be useful to consider different sources at the level of beliefs, feelings and past behaviours.

Belief systems and knowledge systems have common elements yet they each have distinct characteristics (Abelson, 1979). Abelson proposed several main features of a belief system. Belief is different from knowledge, in that the word "belief" implies that there is an alternative explanation possible and that others may view the same item differently, whereas factual "knowledge" is viewed in a similar manner by everyone. If one knows as well as believes in something, then it becomes part of the knowledge system and not the belief

system. Jamieson and Zanna (1989) define knowledge as any information which the individual may possess such as beliefs, norms and emotions. If there is a formal structure by which the individual acquires knowledge, this may lead to rigid thought processes which can prevent the development of free thought, formulation of new hypotheses and access to any other knowledge.

Research has indicated that there may be a relationship between the attitude and the knowledge held by the individual on a certain issue or domain (Pratkanis, 1989). In view of previous research, it would be useful to examine the factual knowledge structure of nurses with respect to palliative care in nursing homes and its relationship to the overall evaluation of the attitude.

The knowledge of the nurses will be measured by cognitive information which is either factual or procedural knowledge about palliative care in nursing homes.

The next section will examine the methodological issues pertinent to this study.

2.6 Methodology

The most common method used in the past to measure the beliefs and emotions or feelings of the participants in studies has been to present them with a list of attributes and ask them to rate the attitude object according to that list (Chaiken & Baldwin, 1981; Krosnick, 1989). This list of attributes contained those features which the participant group would commonly ascribe

to the particular attitude object. Fishbein and Ajzen (1975) called these "modal salient beliefs". The evaluative content of these attributes was decided by the researcher based on the positive and negative meanings assigned to each attribute (Eagly, Mladinic and Otto, 1994). The results of such studies, for example by Fishbein (1965), have recorded moderately high correlations between attitudes and beliefs (Eagly, Mladinic and Otto, 1994).

Problems occur when researchers assess participants' beliefs and emotions by presenting them with a list of responses on a rating scale. For example, Eagly and Mladinic (1989) demonstrated that participants' attitudes towards men and women were predicted by gender-stereotypic characteristics, whereas in the same study these gender-stereotypes also predicted attitudes towards Democrats and Republicans, and participants were therefore seen as possessing the same gender-stereotypes. Eagly, Mladinic and Otto (1994) argued that one cannot assume that because there was a positive correlation between the attitude and the beliefs that were considered to be characteristic of the attitude, that these beliefs formed the basis of the attitude.

This criticism applies equally to researchers who require participants to indicate their affective responses towards an attitude object from a list of typical affective responses towards that attitude object. A positive interpretation by the participant may only mean that the particular emotion symbolises, in some manner, the participants' overall evaluation of the attitude object (Eagly, Mladinic & Otto, 1994). They comment that, as participants are

required to answer all the scales, a positive attitude object is likely to engender feelings of joy, happiness and elation, while they are likely to respond with frustration, unworthiness and bad to a negative attitude object. They further suggest that this standard list of responses generally reflects the overall attitude and not the emotions or feelings associated with the attitude object. They comment that the use of this method to distinguish between the cognitive and affective components of the attitude is unreliable.

Currently, the semantic differential developed by Osgood, Suci and Tannenbaum (1957) is commonly used in measuring attitudes (Himmelfarb, 1993) and is an accepted method of measuring the overall attitude in current research (Eagly & Chaiken, 1993). The scale consists of a series of bipolar adjectives which are commonly separated into seven divisions (see Figure 2.3). This scale allows the participant to indicate their attitude by marking positive or negative points on the scale with respect to a particular attitude object. The idea formulated by Eagly, Mladinic and Otto (1994), is that participants respond to this scale by using their overall attitude and developing beliefs that are related to that attitude. A stimulus object can be evaluated only if the object is comprehended and distinguished at some level by the participant. Eagly, Mladinic and Otto (1994) suggest, there is the potential for participants, when responding to checklists, to construct "attitude - consistent responses" that may somehow be representative of their attitude.

Breckler (1984) argued that although this methodology of using separate checklists for beliefs and emotions may to some extent distinguish between the two components, they should not be used if the aim of the study is to predict the attitude from beliefs and emotions.

An alternative methodology used to examine the cognitive and affective information underlying the attitude has been proposed by Eagly, Mladinic and Otto (1994). This method is known as the free response methodology and has mainly been applied to social groups (e.g., women, men, Democrats, Republicans) and social policies (e.g., abortion on demand, affirmative action in employment, welfare assistance for the poor) by a few researchers (e.g., Haddock, Zanna & Esses, 1993), and has been used successfully in these areas.

A study by Esses, Haddock and Zanna (1993) examined attitudes towards social groups. They were interested in using a different methodology to investigate stereotypes other than adjective checklists and bipolar scales, as they suggested that these types of methodologies prime the participant rather than allowing them to generate their own beliefs and emotions. Their study measured the components of attitudes towards homosexuals and four ethnic groups: English Canadians, French Canadians, Native Indians and Pakistanis. For the symbolic beliefs, participants were required to list values, customs and traditions that they believed were facilitated or hindered by the group, and to rate the extent to which each was facilitated or hindered. For the emotions

measures, participants were asked to generate a list of emotions and feelings that they experienced when they saw, met or thought about members of the group. They found that although 39% of the variance was shared by stereotypes and emotions, symbolic beliefs appeared to be largely independent of both stereotypes and emotions, and therefore seemed to be indicating different information. Emotions seem to be more related to attitude, yet symbolic beliefs and stereotypes did have some predictive power.

The free response methodology was applied in a study conducted by Eagly, Mladinic and Otto (1994), previously described in section 2.4.2, which aimed to generate as many beliefs and affects that "come to mind" in each participant (p.118). They suggested that if participants do not possess the beliefs or emotions with respect to the attitude object, then it was possible that they would develop new ones when confronted with this task. However Eagly, Mladinic and Otto (1994) suggested that if these attitude objects were familiar and significant to the individual then it seemed likely that they would be able to generate some beliefs and affects with respect to the attitude object. The overall evaluation of the attitude is assessed using a semantic differential scale. It is proposed to use this free response methodology in this research.

2.7 Summary of main research

The study of attitudes and attitudinal processes has been of interest to social psychologists. Present interest in the literature focuses on attitudinal

structure. Even though there has been extensive attitudinal research, no agreement has been reached on a single definition of attitudes. Currently most theorists define attitudes in terms of an evaluation of an attitude object. There have been different approaches to the structure of attitudes, including the unidimensional and multidimensional view. The literature lends support to the multidimensional approach of which the tripartite model is an example. Different examples have been proposed using this theory. One such model is that proposed by Zanna and Rempel (1988), which considers attitudes as an evaluation based on three classes of information, namely: cognitive, affective and behavioural. There may also be a relationship between the knowledge of individuals on a certain issue and their attitudes. In order to measure the three classes of information, the free response methodology has been proposed by Eagly, Mladinic and Otto (1994).

The attitude object under consideration in this research is the attitude of nurses to palliative care in nursing homes. It is necessary to consider how to measure the different components of the attitude as well as the overall evaluation of the attitude in the context of palliative care in nursing homes.

2.8 Conclusion and Research Questions

In view of the current literature, nurses' beliefs and knowledge about palliative care may be identified as the critical factor in determining their overall attitudes towards palliative care in nursing homes. Eagly and Chaiken

(1993) indicated that there may be a significant correlation between attitudes and beliefs about the attitude object. Furthermore, there is a general consensus that attitudes and beliefs can be more or less agreeable and therefore nurses who lack information and knowledge of palliative care may be less confident about the area which could influence their attitude. The model proposed by Zanna and Rempel (1988) will be used in the present study to identify whether it is the beliefs of the nurses or their affective information which is the better predictor of the attitudes of nurses to palliative care. In addition, it will be determined whether there is a significant correlation between the knowledge of the nurses and their attitude to palliative care in nursing homes. As stated previously, palliative care is not available in all nursing homes in Perth. There are many residents who are terminally ill in these nursing homes, and for whom palliative care should be an option. As no previous study has focused on this domain, this study is looking at the attitudes of nurses to palliative care in nursing homes rather than in the other established medical facilities where palliative care is already being provided. The free response methodology will be used in this research due to its success in recent research, and its greater validity than rating scale measures for determining the contribution of beliefs and emotions to the overall evaluation of the attitude. The resulting research questions are as follows:

1. Do beliefs and emotions independently and significantly predict attitudes of nurses to palliative care in nursing homes?
2. What beliefs and emotions are generated in response to the attitude object, "palliative care in nursing homes" by the free response methodology?
3. Does knowledge predict the attitudes of nurses to palliative care in nursing homes after beliefs and emotions have been accounted for?
4. Are there any significant differences between (a) directors of nursing, (b) registered nurses and (c) nursing assistants, in their attitudes to palliative care in nursing homes, their beliefs, their emotions or their knowledge?

In order to answer these research questions, an appropriate instrument needed to be developed. The following chapter outlines how this was accomplished and tested in a pilot study in order to establish its reliability and validity.

CHAPTER 3

The Pilot Study

3.1 Purpose of the pilot study

Prior to conducting the main study, several issues needed to be examined. Firstly, the pilot needed to examine the research methodology to be adopted, as this methodology had previously been used only in the social groups and social policies area (Eagly, Mladinic & Otto, 1994). As no suitable instrument was available to collect the data, a new one had to be developed for this purpose. The free response methodology (Esses & Zanna, 1989; Eagly & Mladinic, 1989; Eagly, Mladinic & Otto, 1994) which was adopted for the questionnaire, required participants to generate their own beliefs and emotions in response to the attitude object, "palliative care in nursing homes". The first aim of the pilot, therefore, was to test the free response methodology to determine whether the participants would be able to generate beliefs and emotions in relation to the attitude object "palliative care in nursing homes".

A second consideration concerned the range of responses and potential problems in answering the knowledge questions. There was concern that all nurses may answer some of the knowledge questions in the same manner, as

they may think that a particular response "should" be given. For example, the nurses may reply that they "strongly agree" (even if this was not the actual practice) that a doctor would be consulted prior to administering an analgesic, before the time the next dose was due. To try and avoid this issue, the instrument was developed in an interactive way with nurses, and many of the questions continually refined and revised. However, these issues needed to be examined in the pilot. The second aim of the pilot study, therefore, was to determine whether there was a range of responses for each of the knowledge questions.

A third consideration concerned the reliability of the questionnaire. A two-week interval between responses established whether they were stable over time. Cronbach's Alpha also needed to be computed on the knowledge questions to see if they were internally consistent. The third aim of the pilot study, therefore, was to establish test-retest reliability of the questionnaire and to determine the internal consistency of the knowledge questions using Cronbach's Alpha.

The fourth aim of the pilot was to receive comments from the participants regarding any aspect of the questionnaire. A section was provided at the end of the questionnaire for participants to provide feedback and comments on the questionnaire in general.

As stated in chapter one, no previous research has examined the attitudes of nurses to palliative care in nursing homes. The fifth aim of the

pilot, therefore, was to obtain a preliminary look at the association between attitude, beliefs, emotions and knowledge.

3.2 Method

3.2.1 Participants

The questionnaire was tested on a convenience sample of 30 nurses (25 women and 5 men, mean age = 48.5 years, $SD = 3.5$) who were known to the researcher and her supervisors. The sample represented a diversity of experience in nursing. Four participants were retired of whom one had been a director of nursing, one a clinical nurse specialist, while two had been registered nurses. There were 13 participants who were currently working in hospitals. The remaining 13 participants were lecturers in the School of Nursing at Edith Cowan University. None of the participants in the sample were currently working in nursing homes to avoid overlap with the main study sample. All had expressed their willingness to participate in the pilot testing of the questionnaire.

3.2.2 Instrument

This study used a self-administered questionnaire (see Appendix A) consisting of five categories of questions, comprising a total of 42 questions. Each questionnaire was accompanied by a front page cover (see Appendix B) which introduced the study and addressed issues of purpose and

confidentiality. There were two forms of the questionnaire, Form A and Form B. Both forms were similar, except that half of the participants received section 2 first, followed by section 3 and, the other half, received section 3 first, followed by section 2. In addition, in order to counteract the effect of a response set, the knowledge questions in section 4 were presented in four different sequences.

The first section of the questionnaire provided a measure of the participants' attitudes to palliative care in nursing homes. This used a seven-point bipolar semantic differential scale. The name of the attitude object "palliative care in nursing homes", was written above the scale. Participants were asked to rate palliative care in nursing homes by checking a category on the bipolar scale. The responses were coded from -3 (unfavourable) to +3 (favourable). This score was then used to obtain a total attitude score for each participant as suggested by Eagly and Chaiken (1993). Eagly and Chaiken suggest that there is a high intercorrelation between different bipolar semantic differential scales. Further Haddock, Zanna and Esses (1993) suggest that the assessment of the overall attitude using this method is evaluative and contains no other specific dimensions on the attitude object that is being evaluated. Only one scale was used in previous research by Haddock, Zanna and Esses (1993), namely favourable and unfavourable, and this method was adopted for the present research.

The second and third sections required the participants to rate the extent to which their beliefs and emotions influenced their attitude to palliative care. Through the free response method, previously used by Eagly, Mladinic and Otto (1994), participants were required to write up to 10 personal beliefs (in one section) and emotions (in the other section) about palliative care in nursing homes. They were then asked to indicate, on a 7 point scale, the extent to which each of these beliefs and emotions was favourable or unfavourable to palliative care in nursing homes (Esses, Haddock & Zanna, 1993; Eagly, Mladinic & Otto, 1994). The questionnaires were coded and scored by the researcher. In section 2 and section 3 of the pilot questionnaire, an average score for each section was obtained by adding each individual score and dividing by the total number of scores entered by the participant. For example, if participants entered, +3, +2, +1, +2; the total was +8, and as four scores were entered, +8 was then divided by 4, to obtain a mean score of +2.

In this research, participants were required to write down the beliefs that they believed reflected the attitude object "palliative care in nursing homes" and those emotions they "commonly experienced in relation to it" (Eagly, Mladinic & Otto, 1994, p.118). This method of eliciting beliefs and emotions from the participants allows researchers to use "this simple model that predicts attitudes from the evaluations these respondents attach to these beliefs and affects" (Eagly, Mladinic & Otto, 1994, p.119"). This method allows the researcher to obtain an overall beliefs score and emotions score for

each participant which may be significantly related to the attitude (Eagly, Mladinic & Otto, 1994). They also suggest that "free-response measures of beliefs and affects have satisfactory internal consistency and provide straightforward predictions of attitude" (Eagly, Mladinic & Otto, 1994, p.125).

The fourth section consisted of a collection of statements to measure the knowledge of nurses concerning palliative care in nursing homes (Zanna & Rempel, 1988). Participants were asked to mark on a seven-point scale the extent to which each statement described palliative care in nursing homes. The scale ranged from strongly agree to strongly disagree. These knowledge items were identified from several studies on palliative care (Bennett, 1994; Blackburn, 1989; Damrosch et al. 1993; Degner, Gow & Thompson, 1991; Klein, 1992; Kristjanson, 1986) as well as from members of the WA Hospice Palliative Care Association Research Committee. These items were meant to reflect palliative care as it ought to be practised. Care was taken to try and include only those items which reflected palliative care nursing and not general nursing. As far as possible these knowledge items were framed in neutral terms to try and reduce response bias.

The fifth category of questions comprised a section on demographic data which included items on gender, age, current work status, formal training and education.

At the end of the questionnaire a section was provided for comments concerning the format of the questionnaire as well as any other remarks the participants wished to make.

3.2.3 Procedure

Questionnaires were mailed or handed to the participants. Through random selection half of the participants completed Form A, while the other half completed Form B. The questionnaire required 15-20 minutes to complete. In order to determine test-retest reliability of the questionnaire, the participants were given the same questionnaire after a two week period. Completed questionnaires were then returned to the researcher.

3.3 Results and Discussion

The first aim of the pilot study was to examine the research methodology to establish whether participants could generate emotions and beliefs in response to the attitude object "palliative care in nursing homes". In the pilot study, the participants found no difficulty when asked to elicit their beliefs and emotions in response to the attitude object "palliative care in nursing homes". The beliefs and emotions that were mentioned by the participants are listed in Table 3.1 and Table 3.2. Examples of beliefs included "insufficient understanding of palliative care by nurses"; "lack of adequate training in palliative care for the nurses"; "pain control is

inadequately understood and delivered"; "many nurses do not allow the residents to make their own choices and decisions"; "palliative care aids the comfort of the patient"; "palliative care is useful as it involves multidisciplinary care"; "palliative care allows the family to be involved".

Some of the emotions elicited were "fear", "stress", "concern", "sadness", "hope", "spiritual feeling", "love", "anger", "satisfaction", "confusion", "frustration", "resentment", "compassion" and "relief". There was a range of responses which varied from positive to negative indicating how favourable or unfavourable the beliefs and feelings were to "palliative care in nursing homes". This result showed that the participants were able to generate a range of beliefs and emotions in response to the attitude object "palliative care in nursing homes".

Table 3.1

Frequency and Percentage of Beliefs that were Reported by the Participants in the Pilot Study

Description of Beliefs	N(%)
Lack of education	23(76.7)
Multidisciplinary care	22(73.3)
Inadequate staffing	21(70.0)
Enhances dignity	21(70.0)
Palliative care is beneficial	20(66.7)
Time-consuming	19(63.3)
Pain control inadequately understood	18(60.0)
Includes the family	17(56.7)
Palliative care is underfunded	17(56.7)
Nursing home is the best place for palliative care	17(56.7)
Necessary	14(46.7)
Nurses do not allow residents to make their own choice	13(43.3)
Insufficient understanding of palliative care	13(43.3)
Supportive	12(40.0)
Perceived increase in costs	10(33.3)
Done poorly	10(33.3)
Insufficient facilities	9(30.0)
Religious beliefs met	9(30.0)

Table 3.2

Frequency and Percentage of Emotions that were Reported by the Participants
in the Pilot Study

Description of Emotions	N(%)
Stress in performing palliative care	23(76.7)
Compassion	21(70.0)
Satisfaction for the resident	20(66.7)
Frustration in performing palliative care	19(63.3)
Palliative care offers hope	17(56.7)
Relief	17(56.7)
Confusion over what palliative care represents	13(43.3)
Palliative care gives a spiritual feeling	12(40.0)
Sadness that it is necessary	11(36.6)
Contented	10(33.3)
Love	7(23.3)
Concern for the residents	7(23.3)
Fear of palliative care	3(10.0)
Resentment	3(10.0)
Anger that it is needed	2(.06)

The second aim of the pilot study was to determine whether there was a range of responses for each of the knowledge questions. The responses to the knowledge questions indicated that all of them were marked with a range from 1-7, showing that there was a wide range of answers for all questions. Table 3.3 indicates the mean scores of all the knowledge items in the pilot questionnaire.

The third aim of the pilot study was to establish test-retest reliability of the questionnaire and to determine the internal consistency of the knowledge questions using Cronbach's Alpha. However, before calculating the reliability coefficients, it was necessary to eliminate three knowledge questions, namely questions 7, 10 and 16. Question 7 was eliminated as it was thought by participants to be ambiguous and pertained to ethical issues which were not part of this study. Questions 10 and 16, both concerning nurses listening to patients, were eliminated as they were thought to be ambiguous by respondents, and also lowered Cronbach's Alpha by their inclusion. Cronbach's Alpha was computed on the pretest scores of the remaining 18-item knowledge scale and was .83.

Some participants identified certain knowledge questions that should not appear at the beginning of the knowledge section (Section 4). In the final questionnaire, the questions in the knowledge section were interchanged in different questionnaires in order to avoid ordering effects. Those questions

that were identified as unsuitable to begin the knowledge section were noted to ensure that this did not happen in the main study:

The participants identified two questions (questions 2 and 9) in the knowledge section (Section 4) as being ambiguous or unclear. In Question 2 (see Appendix A), it was commented that the phrase "shielding the family", made it unclear as to whether the nurses were hiding the physical aspects of the disease from the family or the fact that the patient was dying from the disease. Question 2 was altered so that the implication was that nurses refrain from discussing unpleasant aspects of the disease with the family rather than suggesting that they shield the family or by trying to hide the disease from the family. Question 9 (see Appendix A) was made clearer by stressing that the nurse constantly verifies how much information the patient wishes to know and provides only that information, rather than just providing material without checking with the patient.

Table 3.3

Mean Scores of Knowledge Items

Knowledge Item	M(SD)	Skewness	Kurtosis
1	4.23(1.92)	-0.38	-1.51
2	3.97(1.94)	-0.13	-1.58
3	4.33(1.92)	-0.32	-1.30
4	5.37(2.08)	-1.20	0.03
5	4.40(1.98)	-0.46	-1.45
6	3.57(1.89)	0.42	-1.16
7	4.27(1.87)	-0.25	-1.03
8	4.70(1.97)	-0.57	-1.10
9	4.63(1.75)	-0.55	-1.07
10	3.57(1.91)	-0.34	-1.15
11	4.10(2.12)	0.00	-1.63
12	2.63(1.67)	1.34	0.80
13	3.83(1.91)	0.03	-1.41
14	3.50(1.66)	0.73	-0.96
15	3.43(1.94)	0.40	-1.16
16	3.83(1.91)	0.29	-1.31
17	3.80(1.83)	0.14	-1.48
18	4.90(1.71)	-0.94	-0.03
19	3.90(1.88)	0.19	-1.54
20	3.43(1.81)	0.60	-0.96
21	4.43(1.91)	-0.39	-1.23

Pearson product-moment correlation coefficients was calculated to establish test-retest reliability between the first and second administrations of each section of the questionnaire. The results of the Pearson r are presented in Table 3.4 which shows the responses were very stable over the two week period of the study. Due to resource effects and time restraints, only a two week period was allowed between the test-retest. The high correlations indicated in Table 3.4 may be due to memory effects or to the strong reliability of the questionnaire.

Table 3.4

Test-Retest Reliability

Variable	$r(28)$
Attitude	.91***
Beliefs	.95***
Emotions	.95***
Knowledge	.98***

*** $p < .001$

The fourth aim of the pilot was to receive comments from the participants regarding the questionnaire in general. Participants provided a few helpful comments regarding different aspects of the questionnaire. Most of the participants found the questionnaire easy to follow and answer. Their main comments may be summarised: some respondents proposed that examples in the beliefs and emotions sections should be provided before participants are required to complete these sections with respect to palliative care in nursing homes. This suggestion was addressed by providing two examples in each of the beliefs and emotions sections of the questionnaire, as well as examples on how to answer these sections. A more adequate explanation of what was meant by the emotions and beliefs was also included.

The final questionnaire was redrafted and the main issues arising from the pilot study were incorporated. Questions 7,10 and 16 of the draft questionnaire (see Appendix A) were also eliminated. Furthermore, the beliefs and emotions sections of the questionnaire were rearranged and boxes provided for answers. This method created more space for the participants to indicate their answers. It was also decided to place the demographic questions between the sections on beliefs and emotions in order to minimise their influencing one another. This new questionnaire was then used for the main study (see Appendix C).

The fifth and final aim of the pilot study was to enable the researcher to take a preliminary look at the association between attitude, beliefs, emotions

and knowledge. Although the pilot study was based on only 30 participants, who were not working in nursing homes, it provided an opportunity for a preliminary exploration of the results in terms of which was the better predictor of the attitude to palliative care in nursing homes, emotions or beliefs. The indication was that neither the beliefs $r(28) = .50$, $p < .01$ nor the emotions $r(28) = .53$, $p < .01$ can be regarded as the sole predictor of the attitude to palliative care in nursing homes. It is worthwhile noting that the correlation between beliefs and emotions was only $r(28) = .13$, $p > .05$. It appeared that both independent variables may predict the attitude.

Respondents generated similar lists of beliefs and emotions over the two week period, thus making the lists comparable. This is interesting in that the literature has largely ignored the emotions or feelings of the nurses with respect to palliative care. These findings suggest that the emotions of the nurses may need to be considered when examining their attitude to palliative care in nursing homes. However one needs to consider that the participants in the pilot study were not nurses working in nursing homes, and only nine were working in the palliative care area. In the light of this, some of these findings may not be reflected in the main study.

The palliative care literature emphasises the role of knowledge needed by the nurses and other professionals to develop their capabilities in this area. Reimer and Davies (1991) suggested that knowledge and skills needed to be learnt by the nurses to encourage them to develop new approaches to palliative

care. The results from the pilot study indicate that knowledge has a very low correlation with the beliefs that the nurses may hold $r(28) = .12, p > .05$. This result suggests that increasing the knowledge of the nurses with regard to palliative care may not necessarily influence the beliefs of the nurses and therefore their attitude to palliative care in nursing homes. There was a low correlation between knowledge and attitude $r(21) = .31, p > .05$ and a low negative correlation between knowledge and emotions $r(21) = -.10, p > .05$. This suggests that increasing the knowledge of the nurses may not necessarily influence their attitude to palliative care in nursing homes and increasing the knowledge of the nurses may not decrease their emotions to palliative care in nursing homes. Again, this finding may or may not be confirmed by the main study.

3.4 Conclusions

As a result of the pilot study, the questionnaire was modified to reflect the participants' responses. The pilot study provided good test-retest reliability of the questionnaire and an acceptable level of internal consistency of the knowledge questions. The results of this study indicate that emotions and beliefs are moderately and significantly correlated with attitude, yet knowledge is not significantly correlated with attitude.

The following two chapters report the method and results of the main study in which the modified questionnaire (see Appendix C) was administered

to a larger sample of directors of nursing, clinical nurse specialists and registered nurses all of whom were working in nursing homes.

CHAPTER 4

Main Study Method

4.1 Participants

Seventy eight private and public nursing homes in the Perth Metropolitan region were identified, through consulting the East Metropolitan Palliative Care Agency and the Yellow Pages of the telephone book. In each of the nursing homes there was either one director of nursing or one clinical nurse specialist, or, in some of the larger nursing homes, there was one of each. There were also registered nurses, nursing assistants and sometimes enrolled nurses present in each nursing home.

For the study, it was decided that the sample would be formed by three groups of equal sizes. These groups were to be based on the qualifications held by the nurses. The first group would be the directors of nursing and clinical nurse specialists who held postgraduate qualifications and were responsible for the administration and day-to-day running of the nursing home, as well as being in charge of all the other nurses in the nursing home. Group 2 would be registered nurses who had obtained a university qualification, and Group 3 nursing assistants who had no qualifications. Initially it was planned

that enrolled nurses would also be included in the study, but because only 13 returned questionnaires, this category was eliminated from the study.

The directors of nursing and clinical nurse specialists of all 78 nursing homes were invited to participate in this study. In order to obtain equal numbers of registered nurses to directors of nursing and clinical nurse specialists, and to obtain equal numbers of nursing assistants as there were directors of nursing and clinical nurse specialists, 30 of these nursing homes were chosen randomly from the original 78 nursing homes. SPSS for Windows was used to generate a random list of 30 nursing homes which were stratified by size based on a median split. There were two strata, large nursing homes (≥ 60 beds) and small nursing homes (≤ 59 beds). All the registered nurses and nursing assistants working in these 30 nursing homes were invited to take part in this study.

In total 507 questionnaires were mailed to potential participants, and of these 332 were returned completed, which represented a 65% response rate. Two of the nursing homes returned all their questionnaires, and expressed a desire not to participate in the study. The total number of directors of nursing and clinical nurse specialists who completed the questionnaire was $n = 76$. There were also 138 registered nurses, 105 nursing assistants and 13 enrolled nurses who completed and returned the questionnaire, making a total number of 332 respondents in this study. The enrolled nurses, as mentioned earlier, were eliminated from any further analysis due to the small number.

As three equal groups were needed for the study, the group of directors of nursing and clinical nurse specialists determined the total number of nurses for each of the other groups ($n = 76$). Therefore, the number of registered nurses and nursing assistants required for each of the other two groups was $n = 76$. The selection of completed questionnaires to form these two groups from all the returned questionnaires was determined by numbering the questionnaires in each group, generating a random numbered list of numbers from SPSS for Windows, and choosing those questionnaires with the generated numbers.

Therefore, after completion of the random sampling, two random samples of equal numbers of nurses ($n=76$) were obtained from these 30 nursing homes. One sample comprised registered nurses and the other sample consisted of nursing assistants.

Thus three groups of equal sizes ($n = 76$) formed the total sample:

1. Directors of nursing and Clinical nurse specialists
2. Registered nurses
3. Nursing assistants

4.2 Demographic Data

The demographic data for each group are summarised in Table 4.1.

There were 228 nurses who participated in the study. The sample consisted of 115 women and 13 men, whose age ranged from 20 to 64 years (mean age =

42.80 years, $\underline{SD} = 10.11$). At the time of the study, the nurses had been working in nursing homes for an average period of 6.42 years ($\underline{SD} = 5.29$). The mean number of years that they had been in the nursing profession was 18.60 years ($\underline{SD} = 10.62$). Of the total sample, 90 nurses (39.5%) reported having previously practised palliative care, while 161 nurses (71.2%) indicated that they were currently practising palliative care. There were 163 nurses (71.5%) who had had experience with a close friend or relative dying. There were 37 nurses (16.3%) who reported that they had received education in palliative care in their undergraduate training, while 28 nurses (12.2%) had been involved in postgraduate training. There were 84 (36.84%) nurses who had received ongoing professional training in the form of seminars, workshops or attending courses at the Cottage Hospice.

Table 4.1

Demographic Data for Each Group of Nurses

Variables	Directors of Nursing Clinical Nurse Specialists	Registered Nurses	Nursing Assistants
Mean Age ¹	47.30 (8.54)	43.73 (9.33)	37.42(9.90)
Number of Years in Practice ¹	23.46 (8.72)	20.91 (9.92)	11.44 (9.25)
Number of Years Working in the Nursing Home ¹	7.87 (5.63)	6.39 (5.34)	4.95 (4.47)
Gender ²	73 (96.1%)	75 (98.7%)	67 (88.2%)
Previously Practiced Palliative Care ²	30 (39.5%)	30 (39.5%)	30 (39.5%)
Currently Practicing Palliative Care ²	54 (71.1%)	52 (68.4%)	55 (72.4%)
Experience with Close Friend or Relative Dying ²	60 (78.9%)	57 (75%)	46 (60.5%)
Received Undergraduate Education in Palliative Care ²	14 (18.4%)	16 (21.1%)	7 (9.2%)
Received Postgraduate Education in Palliative Care ²	19 (25%)	9 (11.8%)	0 (0.0%)
Received Professional Training ²	48 (63.2%)	29 (38.2%)	7 (9.2%)

¹Means and standard deviations are given for these variables as follows: M (SD)

²Frequencies are given with percentages inside parentheses. In the case of gender, number and percentages of females are given.

4.3 The Questionnaire

This study used a self-administered questionnaire (see Appendix C) which consisted of 14 pages and five sections, comprising a total of 33 questions and requiring 15-20 minutes to complete. Each questionnaire was accompanied by a front cover page (see Appendix D) which introduced the study and addressed issues of confidentiality. No identifying information was required of the participants, and they were assured of total anonymity. The name and contact number of the researcher and two supervisors were also included. There were two forms of the questionnaire, Form A and Form B, both forms were the same, except that half of the participants through random selection received section 2 first, followed by sections 3 and 4 and, the other half, received section 4 first, followed by sections 3 and 2. In addition, the knowledge sections in section 5 were presented in four different sequences, in order to counteract the effect of a response set.

The first section of the questionnaire provided a measure of the attitude to palliative care in nursing homes. This was similar to that described in chapter 2 of the pilot study. However the bipolar semantic differential scale was reversed here for ease of scoring. The responses were therefore coded from -3 (unfavourable) to +3 (favourable) to obtain a total attitude score for the participant.

The second and fourth sections required participants to generate beliefs and emotions with respect to the attitude object "palliative care in nursing

homes" and to then rate the extent to which these beliefs and emotions influenced their attitude to palliative care in nursing homes. Two examples, both positive and negative, were provided for each section to illustrate to the participants how to complete these sections. These illustrations used attitude objects from the natural environment, namely "whether whaling should be allowed to continue" and "logging in natural forests". Boxes were provided in section two and four in which the participants could write their responses. All other details regarding the scoring and methodology used in sections two and four are as described in chapter 3.

The third section requested general demographic information as previously described in chapter 2.

The fifth section consisted of a collection of 18 statements to measure the knowledge of the nurses concerning palliative care in nursing homes (Zanna & Rempel, 1988).

4.4 Procedure

All directors of nursing and clinical nurse specialists in 78 nursing homes were mailed individual questionnaires. Enclosed in each envelope was a stamped addressed envelope for the return of the individual questionnaires to the researcher.

In order to obtain participants for the other two groups, namely, registered nurses and nursing assistants, a random sample of 30 of these

nursing homes from the original 78 nursing homes was chosen. It was then necessary to determine the number of nurses working in these 30 nursing homes. This information was obtained through the WA Hospice Palliative Care Association Research Group and by telephoning some of the nursing homes. The number of questionnaires required for each nursing home was determined by the total of all the registered nurses, nursing assistants and enrolled nurses in each of the 30 nursing homes that were identified as the sample. The total number of questionnaires required for each of the 30 nursing homes was placed in one Australia Post "Postpak" and addressed to the director of nursing or clinical nurse specialist of the nursing home. A stamped addressed "Postpak" was provided for the return of the questionnaires.

Enclosed in each envelope or Postpak was a letter from the WA Hospice Palliative Care Association Research Group which introduced the researcher to the director of nursing or the clinical nurse specialist, explaining the interest of the research group in the study and the results and requesting their support for the study (see Appendix E). Attached to each questionnaire was a letter explaining the nature of the study and addressing the issues of confidentiality (see Appendix F). A separate envelope was also attached to each questionnaire. A label on the front of this envelope gave the following instructions:

1. Place completed questionnaire in this envelope.

2. Return the envelope to the Director of Nursing

Thank you for your time in completing this questionnaire

This allowed complete confidentiality for the nurses in completing the questionnaire.

The bulk questionnaires were delivered by courier to each of the 30 nursing homes, whereas single questionnaires were posted to the directors of nursing or clinical nurse specialists of the remaining 48 nursing homes. The directors of nursing or clinical nurse specialists of each nursing home were telephoned by the researcher about four days after the initial posting of the questionnaires. This served to ensure that they had received the questionnaires, to encourage them to participate in the research, and to give them an opportunity to ask any questions. The directors of nursing or clinical nurse specialists, together with all the nurses, were invited to contact the researcher if any queries or problems arose with the research or the questionnaire.

4.5 Data Coding

The questionnaires were coded and scored by the researcher. In section 2 (Beliefs) and section 4 (Emotions) of the questionnaire, an average score for each section was obtained by adding each individual score and dividing by the total number of scores entered by the participant. For example, if participants entered the following scores: +3, +2, +1; the total was +6, and as three scores were entered, +6 was then divided by 3, to obtain a mean score of +2.

A copy of the coding sheet for the knowledge section of the questionnaire is included in Appendix G. The data were entered onto a computer spreadsheet by the researcher using SPSS for Windows. The calculation of the beliefs and emotions scores and the entry of all the data from the questionnaires onto SPSS were then checked by a colleague of the researcher, who had been trained in the scoring procedure. Two errors were identified by the colleague and amended prior to the statistical analysis of the data.

4.6 Ethical Considerations

The Ethics Committee of Edith Cowan University approved this research with the stipulation that the following ethical procedures were implemented.

1. Participants were guaranteed that confidentiality and anonymity would be maintained at all times. To ensure this, the front page cover of the questionnaire clearly identified this issue and participants were specifically instructed that no names or addresses or other identifying information was required.
 2. The researcher and her supervisors were clearly named on the front cover of the questionnaire with their respective telephone numbers.
- Participants were encouraged to contact the researcher or her supervisors in the event of any query regarding the research in general or the questionnaire.

3. The qualifications of the researcher were stated together with the institution and the degree being undertaken.
4. Participants were advised that they could refuse to take part in the research without penalty. They could also decline to answer any question and withdraw from the study at any stage.
5. No letters of consent were completed by the participants, but completion and subsequent return of the questionnaire was regarded by the researcher as consenting to participate in this study.

CHAPTER 5

Main Study Results

This chapter reports the reliability of the questionnaire and considers each of the research questions in turn, starting with the contribution of beliefs and emotions to the attitudes of nurses to palliative care in nursing homes. This will be followed by a description of the beliefs and emotions generated by the participants. Leading from this, the contribution of knowledge to the attitudes of nurses to palliative care will be considered. Further results on education in palliative care and the attitude-behaviour relationship will be presented. Finally the differences between the groups of nurses will be examined, followed by a summary of the main findings from this study.

5.1 Reliability of the Questionnaire

The pilot study established the reliability of the questionnaire. The internal consistency of the knowledge questions was established using Cronbach's Alpha with items being changed or modified due to suggestions given by the participants in the pilot study. Cronbach's Alpha was also computed on the 18-item knowledge scale in the main study and was .75. On

examination of the items none significantly lowered the Cronbach's Alpha by their inclusion.

5.2 The contribution of beliefs and emotions to the attitudes of nurses to palliative care in nursing homes.

The first research question concerned whether beliefs and emotions independently and significantly predict attitudes of nurses to palliative care in nursing homes.

In order to answer this question, correlations and multiple regression were employed to determine if beliefs and emotions predicted the attitudes of nurses working in nursing homes.

A standard multiple regression was performed in which attitudes of nurses to palliative care in nursing homes was the dependent variable and beliefs and emotions were the independent variables. The analysis and all others reported here were performed using SPSS for Windows.

To evaluate the assumptions of regression, the guidelines outlined in Tabachnick and Fidell (1989) were followed and the data were examined for univariate outliers by examining standardised scores and histograms and none were identified. Mahalanobis' distance ($p < .001$) identified no multivariate outliers. Univariate normality, linearity and homoscedasticity were established by examining residual scatterplots (see Appendix H). Multivariate normality was also checked through a histogram of standardised residuals (see

Appendix I). The results of the multiple regression should be interpreted with caution. No cases had missing data.

The assumptions of multiple regression were therefore met. However, on examination of the data, the distribution of the dependent variable, attitude to palliative in nursing homes, was bimodal (see Appendix J), showing that the attitudes of nurses to palliative care in nursing homes were divided into two main groups: namely, nurses with a positive attitude to palliative care in nursing homes and nurses with a negative attitude to palliative care in nursing homes. In this sample, the bimodal distribution shows the strength of this sample's attitudes towards palliative care in nursing homes as only four of the participants indicated a neutral attitude. All other participants had either a positive or a negative attitude to palliative care in nursing homes. (This pattern of prediction was not observed in the pilot study.)

However, since the assumptions described above were all met, it was decided to proceed with the multiple regression as originally planned, and to compare the results with those of a discriminant analysis which, as briefly described below, yielded the same results.

Table 5.1 displays the correlations between the variables for all the nurses. As apparent from Table 5.1, beliefs $r(226) = .68, p < .001$ and emotions $r(226) = .61, p < .001$ were similarly, strongly positively correlated with attitude and were significantly correlated with each other; $r(226) = .43, p < .001$.

Table 5.1

Correlations between Variables for All the Nurses

Variable	Beliefs	Emotions
1. Attitude	.68***	.61***
2. Beliefs		.43***

*** $p < .001$

Table 5.2

Standard Multiple Regression of Beliefs and Emotions on Attitude for All Nurses to Palliative Care in Nursing Homes

Variables	B	β
Beliefs	.56***	.51
Emotions	.43***	.39

Intercept = 4.19

*** $p < .001$

Note. $R^2 = .58$; Adjusted $R^2 = .58$; $R = .76$

The results of the multiple regression are shown in Table 5.2. The multiple R for regression was significantly different from zero, $F(2,225) = 156.82$, $p < .001$. Furthermore, both beliefs and emotions contributed significantly to the prediction of attitudes of nurses to palliative care in nursing homes.

Table 5.2 indicates an overall result for all the participants in the study. Different patterns may be exhibited by each group of participants, as they perform different functions within the nursing home. It was decided to investigate whether the independent variables of beliefs and emotions significantly and independently predict attitudes of each group of participants to palliative care in nursing homes.

A standard multiple regression was performed for each group and the results are summarised separately. Tables 5.3, 5.5, and 5.7 provide the correlations between the variables for directors of nursing and clinical nurse specialists, for registered nurses and for nursing assistants respectively. Tables 5.4, 5.6 and 5.8 provide the results of the standard multiple regression for each group.

The correlations between the variables for each group and their attitudes to palliative care in nursing homes indicated that beliefs and emotions were similarly, strongly, positively correlated with attitude and were significantly correlated with each other.

In the multiple regression for each group, the multiple R for the regression was significantly different from zero: in the group of directors of nursing and clinical nurse specialists, $F(2, 73) = 41.57, p < .001$; in the group of registered nurses $F(2, 73) = 52.59, p < .001$; in the group of nursing assistants $F(2, 73) = 54.64, p < .001$. Furthermore, both beliefs and emotions, contributed significantly to the prediction of attitudes for each group.

In summary, the two independent variables of beliefs and emotions predicted the attitude significantly and independently for all the nurses as well as for each group of nurses in the sample.

Table 5.3

Correlations between Variables for Directors of Nursing and Clinical Nurse Specialists

Variable	Beliefs	Emotions
1. Attitude	.62***	.63***
2. Beliefs		.46***

*** $p < .001$

Table 5.4

Standard Multiple Regression of Beliefs and Emotions on Attitude for
Directors of Nursing and Clinical Nurse Specialists to Palliative Care in
Nursing Homes

Variables	B	β
Beliefs	.50***	.42
Emotions	.45***	.44
Intercept = 4.28		
*** $p < .001$		

Note. $R^2 = .53$; Adjusted $R^2 = .52$; $R = .73$

Table 5.5

Correlations between Variables for Registered Nurses

Variable	Beliefs	Emotions
1. Attitude	.72***	.60***
2. Beliefs		.52***
*** $p < .001$		

Table 5.6

Standard Multiple Regression of Beliefs and Emotions on Attitude for
Registered Nurses to Palliative Care in Nursing Homes

Variables	B	β
Beliefs	.61***	.57
Emotions	.35**	.30
Intercept = 4.17		
p<.01 *p<.001		

Note. $R^2 = .59$; Adjusted $R^2 = .58$; $R = .77$

Table 5.7

Correlations between Variables for Nursing Assistants

Variable	Beliefs	Emotions
1. Attitude	.65***	.58***
2. Beliefs		.29*
*p<.05 ***p<.001		

Table 5.8

Standard Multiple Regression of Beliefs and Emotions on Attitude for Nursing Assistants to Palliative Care in Nursing Homes

Variables	B	β
Beliefs	.58***	.53
Emotions	.48***	.43
Intercept = 4.13		
*** $p < .001$		

Note. $R^2 = .60$; Adjusted $R^2 = .59$; $R = .77$

5.3 Description of Beliefs and Emotions generated

The second research question asked what beliefs and emotions are generated in the present domain by the free response methodology. It was reported earlier that beliefs and emotions significantly and independently predicted the attitudes of nurses to palliative care in nursing homes. Therefore it is important to examine the descriptions of the actual beliefs and emotions that were generated by the participants, firstly, to identify the different beliefs and emotions; secondly, to identify the types of beliefs that were generated

and whether they were accurate; and thirdly, to identify whether participants confused beliefs and emotions. A wide range of beliefs and emotions was generated. There were 57 beliefs and 63 emotions. Those beliefs and emotions that were mentioned by more than 10% of the sample are listed in Table 5.9 and Table 5.10. Table 5.9 displays the beliefs and the percentage with which they occurred in the sample. Table 5.10 displays the emotions and the percentage with which they occurred in the sample. A complete list of all the beliefs and emotions generated by the participants is included in Appendix K.

In Table 5.9, the beliefs which occurred with the highest frequency reflected the positive aspect of palliative care in terms of caring for the person who is terminally ill. This included the belief that palliative care was both good for the person who was terminally ill and better than other options, that it was essential to have palliative care, and that residents should be kept pain free. Nurses also expressed the belief that the family needs to be involved in palliative care and that the wishes of both the family and resident need to be taken into account. Other sections of the multidisciplinary team are alluded to among the beliefs. For example some nurses believed that doctors need to understand palliative care. Education was seen as important both for doctors and nurses. Reference was also made to the necessity of having adequate staff to carry out palliative care, the need for support from others, yet acknowledging the role of the nurse in palliative care.

Table 5.9

Frequency and Percentage of Beliefs that were Reported by more than 10% of the Participants

Description of Beliefs	N (%)
Better option for resident and family	77(33.8)
Palliative care is good for the patient	64(28.1)
Need for education by doctors and nurses	50(21.9)
Palliative care is essential	47(20.6)
Residents should be kept pain free	43(18.9)
Family needs to be involved	42(18.4)
Dignity for the patient	38(16.7)
Wishes of the family and resident need to be upheld	35(15.4)
Needs to be support from others for the resident	33(14.5)
Care of residents and families	32(14.0)
Doctors need to understand palliative care	27(11.8)
It is the nurse's role to provide palliative care	26(11.4)
Staff are needed to carry out palliative care	23(10.1)

Table 5.10

Frequency and Percentage of Emotions that were Reported by more than 10% of the Participants

Description of Emotions	N (%)
Sad	103(45.2)
Anger	60(26.3)
Frustrated	55(24.1)
Satisfied	55(24.1)
Happy	32(14.0)
Inadequate	25(11.0)
Useful	25(11.0)
Good	24(10.5)

In Table 5.10, four of the emotions were negative while four were positive. Sadness was generated with the highest frequency followed by anger and frustration. It appears that negative emotions were more frequently generated than positive ones. However there were positive emotions which included "good", "happy", "satisfied" and "useful".

On examining the different beliefs and emotions that were generated by the participants, there appeared to be no confusion by the participants of the

difference between beliefs and emotions. Participants were able to generate beliefs and emotions accurately when required.

5.4 The contribution of knowledge to the attitude of nurses to palliative care in nursing homes.

The third research question asked whether knowledge predicts the attitudes of nurses to palliative care in nursing homes after beliefs and emotions have been accounted for. In order to answer this question, a hierarchical multiple regression was used. In examining Table 5.11, which displays the correlations between the variables and knowledge for all the nurses, it can be seen that knowledge was significantly correlated with attitude, $r(226) = .38, p < .001$. Although this correlation is significant, it is lower than the correlation between the other two independent variables and attitude, shown in Table 5.1.

Table 5.11
Correlation between the Variables and Knowledge for All the Nurses

Variable	Knowledge
1. Attitude	.38***
2. Beliefs	.29***
3. Emotions	.39***

*** $p < .001$

Table 5.12 displays the hierarchical regression for all the predictor variables, with beliefs and emotions entered at step 1, and knowledge at step 2 as specified below. For step 2, knowledge added very little to the prediction of attitudes of nurses to palliative care in nursing homes, $\Delta R^2 = .01$ (adjusted $\Delta R^2 = .005$), $F_{inc}(3, 224) = 3.87$, $p = .05$. Addition of knowledge to the equation was only just significant.

Table 5.12

Hierarchical Regression of Predictor Variables on Attitude for All Nurses to Palliative Care in Nursing Homes

Variables	B	β
Step 1		
Beliefs		
Emotions	.40***	.36
Step 2		
Knowledge	.02	.09
Intercept = 2.90		

*** $p < .001$

Note. $R^2 = .58$ for step 1; $\Delta R^2 = .01$ after step 2.
 β weights for step 1 calculated after step 1.

Each group of participants had different education, training and experience, therefore the pattern of whether knowledge adds to the prediction of attitude to palliative care in nursing homes for each group may differ. It was decided to investigate whether knowledge adds significantly to the

prediction of attitudes to palliative care in nursing homes for each group of nurses.

A hierarchical multiple regression was used for each group and the results are summarised separately. Table 5.13 displays the correlation matrix between the variables and knowledge for each group of nurses. It can be seen that knowledge was significantly correlated with the attitude in all three groups. In the group of nursing assistants, it was significant at exactly .001.

Table 5.13

Correlations between the Variables and Knowledge for Each Group of Nurses

Variables	Directors of Nursing Clinical Nurse Specialists	Registered Nurses	Nursing Assistants
	Knowledge	Knowledge	Knowledge
Attitude	.35**	.40***	.37**
Beliefs	.12	.46***	.24*
Emotions	.27*	.32**	.61***

* $p < .05$

** $p < .01$

*** $p < .001$

Tables 5.14, 5.15 and 5.16 display the hierarchical regression for each group of participants. For the directors of nursing and clinical nurse specialists, at step 2, knowledge added significantly to the prediction of

attitudes of directors of nursing and clinical nurse specialists to palliative care in nursing homes, $\Delta R^2 = .04$ (adjusted $R^2 = .03$), $F_{inc}(3, 72) = 6.124$, $p < .05$.

For the group of registered nurses, after step 2, knowledge did not add significantly to the prediction of attitudes of registered nurses to palliative care in nursing homes, $\Delta R^2 = .003$ (adjusted $\Delta R^2 = .003$), $F_{inc}(3, 72) = .486$, $p > .05$.

Also for the group of nursing assistants, knowledge did not add significantly to the prediction of attitudes of nursing assistants to palliative care in nursing homes, $\Delta R^2 = .00$ (adjusted $\Delta R^2 = .005$), $F_{inc}(3, 72) = .175$, $p > .05$.

In summary the addition of knowledge to the equation after beliefs and emotions had been accounted for, was just significant for the whole sample, significant only for the directors of nursing and clinical nurse specialists, and not for registered nurses and nursing assistants.

Table 5.14

Hierarchical Regression of Predictor Variables on Attitude for Directors of
Nursing and Clinical Nurse Specialists to Palliative Care in Nursing Homes

Variables	B	β
Step 1		
Beliefs		
Emotions	.39***	.38
Step 2		
Knowledge	.03*	.20
Intercept = 1.60		

* $p < .05$ *** $p < .001$

Note. $R^2 = .53$ for step 1; $\Delta R^2 = .04$ after step 2.

β weights for step1 calculated after step 1.

Table 5.15

Hierarchical Regression of Predictor Variables on Attitude for Registered Nurses to Palliative Care in Nursing Homes

Variables	B	β
Step 1		
Beliefs		
Emotions	.35**	.29
Step 2		
Knowledge	.01	.06
Intercept = 3.37		

** $p < .01$

Note. $R^2 = .59$ for step 1; $\Delta R^2 = .003$ after step 2

Table 5.16

Hierarchical Regression of Predictor Variables on Attitude for Nursing Assistants to Palliative Care in Nursing Homes

Variables	B	β
Step 1		
Beliefs		
Emotions	.50***	.46
Step 2		
Knowledge	-.007	-.04
Intercept = 4.74		

*** $p < .001$

Note. $R^2 = .60$ for step 1; $\Delta R^2 = .001$ after step 2.
 β weights for step1 calculated after step 1.

5.5 Education in Palliative Care

There were several demographic questions in the questionnaire which may provide an insight into the relationship between knowledge and attitudes. In view of the above findings, the questions on whether nurses received undergraduate (see Appendix C, question 9) and postgraduate education (see Appendix C, question 10) and whether they have attended workshops and

seminars (see Appendix C, question 11), may provide interesting findings, although these must be regarded as only tentative as this area needs to be examined in more detail. As nursing assistants do not receive any formal training, it was decided to eliminate this group from this part of the analysis.

Table 5.17

Comparison of Attitude by Education for Directors of Nursing, Clinical Nurse Specialists and Registered Nurses

Variable	Education or Training	No education or Training	t
	<u>M</u> (<u>SD</u>)	<u>M</u> (<u>SD</u>)	
Undergraduate Education	5.40(1.87)	4.67(2.41)	1.80(df=55.66)
Postgraduate Education	5.21(2.06)	4.74(2.38)	1.06(df=44.84)
Received Professional Training	5.12(2.14)	4.53(2.48)	1.55(df=145.57)

As displayed in Table 5.17, there was no significant difference between the attitudes of those nurses who had received undergraduate or postgraduate education in palliative care and the attitudes of those who had not. Attending

workshops and seminars on palliative care (professional training) also did not distinguish the attitudes of nurses to palliative care in nursing homes.

Levene's Test for Equality of Variances was used to compare the variances before doing any of the t-tests. In Table 5.17, Levene's Tests showed variances to be unequal and therefore separate variances was used rather than pooled variances in performing the t-value. The number of directors of nursing, clinical nurse specialists and registered nurses who received undergraduate ($n = 37$) and postgraduate education ($n = 28$) and attended seminars and workshops ($n = 84$) is shown in Table 4.1.

Table 5.18

Comparison of Knowledge by Education for Directors of Nursing, Clinical Nurse Specialists and Registered Nurses

Variable	Education or	No education or	t
	Training	Training	
	<u>M</u> (<u>SD</u>)	<u>M</u> (<u>SD</u>)	
Undergraduate Education	88.37(12.19)	84.37(14.87)	1.36(df=149)
Postgraduate Education	87.68(15.82)	84.53(14.05)	1.05(df=150)
Received Professional Training	87.29(13.82)	82.88(14.71)	1.90(df=150)

Similarly as displayed in Table 5.18, there was no significant difference between the knowledge of palliative care of those nurses who had received undergraduate or postgraduate education in palliative care and those who had not. Attending workshops and seminars on palliative care was also not significant for the knowledge of nurses to palliative care in nursing homes. These results should be interpreted with caution because of the violation of assumption. These results for education tend to confirm the finding reported in the earlier section that the extent of knowledge does not greatly distinguish nurses with positive attitudes to palliative care in nursing homes from nurses with negative attitudes.

5.6 Attitude and behaviour

The previous section examined the knowledge and education of the nurses in the sample. However, it did not take into account the actual practice of palliative care by these nurses. Many other attitudinal studies have not used a behavioural measure and although the aim of this study was not to measure behaviour, the demographic data of the study provided the researcher with two rough measures of behaviour, namely: whether participants had previously practised palliative care; whether participants were currently practising palliative care.

The attitudes of those who were currently working in palliative care were compared with the attitudes of those who were not currently working in palliative care by means of independent sample *t*-tests, the results of which are shown in Table 5.19. Table 5.19 shows differences for all but the directors of nursing and clinical nurse specialists, indicating that those who were currently practising palliative care were significantly more likely to have a positive attitude than those who were not.

Table 5.19

Mean Attitude Score by Current Experience with Palliative Care

	Current experience <u>M</u> (<u>SD</u>)	No current experience <u>M</u> (<u>SD</u>)	<u>t</u>
Directors of Nursing Clinical Nurse Specialists	5.24 (2.29)	5.23 (2.20)	0.02 (<u>df</u> =74)
Registered Nurses	5.00 (2.12)	3.00 (2.26)	3.69*** (<u>df</u> =73)
Nursing Assistants	5.00 (2.37)	3.65 (2.50)	2.15* (<u>df</u> =73)
Total	5.08 (2.25)	3.95 (2.47)	3.18**(<u>df</u> =109.23)

* $p < .05$ ** $p < .01$ *** $p < .001$

Table 5.20

Mean Attitude Score by Previous Experience with Palliative Care

	Previous experience <u>M (SD)</u>	No previous experience <u>M (SD)</u>	<u>t</u>
Directors of Nursing Clinical Nurse Specialists	5.17 (2.37)	5.28 (2.20)	-0.22 (<u>df</u> =74)
Registered Nurses	4.47 (2.35)	4.39 (2.37)	0.14 (<u>df</u> =74)
Nursing Assistants	4.97 (2.22)	4.48 (2.61)	0.87 (<u>df</u> =68.75)
Total	4.87 (2.30)	4.72 (2.41)	0.46 (<u>df</u> =226)

However, on examining Table 5.20, there is no significant difference in attitude to palliative care in nursing homes between the nurses who had previously worked in palliative care and those who had not.

5.7 Differences between the groups of nurses

The fourth research question asked whether there were any differences between the groups in the four components of the attitude model. In order to answer this question, four one-way ANOVAs were used to determine if there were any significant differences between the three groups on the basis of attitude to palliative care in nursing homes, beliefs, emotions and knowledge. The results are displayed in Table 5.21.

Differences were detected only on beliefs and knowledge. Tukey's honestly significant difference tests showed that for beliefs, there was a significant difference ($p < .05$) between the directors of nursing and clinical nurse specialists group and the registered nurses group (difference between the means = 0.84), but not between any of the other groups. For knowledge, there was a significant difference ($p < .05$) between the directors of nursing and clinical nurse specialists group and nursing assistants group (difference between the means = 7.18), but not between any of the other groups.

5.21

Summary of Differences between the Groups in Attitudes, Beliefs, Emotions and Knowledge

	Directors of Nursing Clinical Nurse Specialist	Registered Nurses	Nursing Assistants	
	<u>M (SD)</u>	<u>M (SD)</u>	<u>M (SD)</u>	<u>F (2,225)</u>
Attitudes	5.24 (2.25)	4.42 (2.35)	4.67 (2.46)	2.40
Beliefs	1.32 (1.87)	0.48 (2.19)	0.74 (2.24)	3.16*
Emotions	0.65 (2.19)	-0.11 (1.98)	0.23 (2.23)	2.42
Knowledge	86.66(14.31)	83.57 (14.40)	79.47 (12.44)	5.22*

05

5.8 Summary

The results indicate that the pattern of prediction is different for all the groups. In the entire sample of nurses ($n = 228$), beliefs and emotions significantly and independently predicted the attitudes of nurses to palliative care in nursing homes. However knowledge also significantly and independently predicted attitudes beyond beliefs and emotions, although only just. Whether or not nurses had previously worked in palliative care did not significantly predict their attitudes to palliative care in nursing homes, whether they were currently working in palliative care did.

For the directors of nursing and clinical nurse specialists, beliefs and emotions both significantly and independently predicted the attitude of directors of nursing and clinical nurse specialists to palliative care in nursing homes. However, knowledge also significantly and independently predicted attitudes beyond these. Whether or not they had previously worked in palliative care did not significantly predict their attitudes to palliative care in nursing homes, and neither did whether they were currently working in palliative care.

For the other two groups of registered nurses and nursing assistants, the results were similar. Beliefs and emotions both significantly and independently predicted the attitude of registered nurses and nursing assistants to palliative care in nursing homes. However, knowledge did not significantly predict their attitude beyond these. Whether or not they had previously

worked in palliative care did not significantly predict their attitude; whether they were currently working in palliative care did.

CHAPTER 6

Discussion

This study investigated the cognitive and affective bases of the attitudes of nurses towards palliative care in nursing homes. In view of the problems previously discussed with using checklists or rating scales, the free response methodology was used to generate the beliefs and emotions of the participants. Firstly, attitudes of the nurses and the relationship between beliefs and emotions will be reviewed in the context of the framework used in this research, namely the model proposed by Zanna and Rempel (1988). The application of the free response methodology which was used to generate the beliefs and emotions of the participants to palliative care in nursing homes will then be discussed. Thirdly, the contribution of knowledge to the attitude of nurses to palliative care in nursing homes will also be examined, followed by a brief section on the relationship between behaviour and the attitudes of nurses. Finally, practical implications of this research and suggestions for future research in the area will be considered.

6.1 Predicting Attitudes from Beliefs and Emotions

The first research question asked whether beliefs and emotions independently and significantly predict attitudes of nurses to palliative care in nursing homes. The model proposed by Zanna and Rempel (1988) suggested that an "attitude is the categorisation of a stimulus object along an evaluative dimension, and can be based on three classes of information, namely: cognitive information; affective or emotional information; and information concerning past behaviors or behavioral intentions"(p. 321). Zanna and Rempel (1988) stress that not all three classes of information are necessary, and that attitudes may be based on one of the three classes of information or a combination. In the present study, the results showed that the attitude to palliative care in nursing homes was based on at least two classes of information: cognitive information or beliefs and affective information or emotions. Further, both beliefs and emotions significantly and independently predicted the attitudes of nurses to palliative care in nursing homes.

As previously described (Chapter 3) a pilot study was conducted prior to the main study for this research. Although the pilot study was based on only 30 participants, who were not working in the palliative care area, the results were similar to the main study and can be considered reliable, because of the similarity between the pilot and main study results. This finding was unexpected at the time because the literature had largely ignored the emotions

and feelings of the nurses. Neither beliefs nor emotions could be regarded as the sole predictor of the attitude, as both significantly predicted the attitude of nurses to palliative care in nursing homes.

Previous studies in the area of social groups and social policies have tended to find that overall, beliefs rather than emotions were better predictors of the attitude (Eagly, Mladinic & Otto, 1994). That beliefs predict attitudes is consistent with other areas, but the role of emotions as a major predictor of the attitude is contrary to many studies. However, emotions were found to be a significant predictor in a study by Abelson et al. (1982), who suggested that affective information is more important to attitudes than cognitive information. In addition, Breckler and Wiggins (1989) and Esses, Haddock and Zanna (1993) found affect significant in determining the attitude of participants. One reason for the difference in results - that beliefs in some studies and emotions in others is more important to the attitude - could be accounted for by the difference in the attitude objects.

This present research used "palliative care in nursing homes" as the attitude object and found both beliefs and emotions to be equally significant. This result cannot be generalised for all attitude domains, the evidence presented thus far in the literature points to different classes of information being the basis of the attitude, depending on the attitude object. This is supported by Breckler and Wiggins (1989), who suggested that affect and cognition may be associated with different attitudinal functions.

If then, different attitudes are based on emotions or cognitions depending on the attitude object. What is it about the attitude object “palliative care in nursing homes” that it should depend on both emotions and cognitions? An examination of the actual beliefs and emotions generated by the participants, may give an indication on what the attitude was based. These may be divided into five areas:

- (a) Spiritual concerns
- (b) Concern about societal attitudes towards nurses
- (c) Misunderstandings about palliative care
- (d) Personal demands and personal rewards for nurses
- (e) Effects of the multidisciplinary approach

Each of the above will be addressed in the following section.

Regarding spiritual concerns, some of the emotional responses of the participants were that nurses felt “inspired”, “thankful”, and “compassionate”. Interestingly, many of the nursing homes (60%) in the Perth metropolitan region are under the auspices of a religious organisation. The ethos in these nursing homes may be one of concern and high regard for the residents based on religious principles. It may be suggested that some nurses are projecting themselves, in terms of these principles, in caring for others.

Beliefs included that “palliative care considers the spiritual need of the resident”, “palliative care needs a special type of carer” and “palliative care is rewarding for staff.” These statements reflect the nurses’ beliefs of palliative

care being a distinct type of care for the resident which is dependent on the type of person who administers that care and the beliefs that they hold. The phrase "palliative care divides health carers because of their own beliefs" reflects a certain assumption or view of caring that nurses may subscribe to in order to practise palliative care.

One of the reasons for the negative attitudes of nurses may be that they reflect a set of mental attitudes which are prevalent in society. People who do not practise palliative care may not be aware of what it is and the type of care that is involved. Evidence of this type of thinking can be seen in statements such as nurses are "afraid of stepping out of line", "afraid of litigation", and palliative care is "too politicised". Even though nurses may wish to practise palliative care, the nurses' concerns about how society may regard them, that is the social desirability, may lead them to develop a negative reaction and a negative attitude towards palliative care (Cook, 1987). Currently, evidence for this suggestion is only tenuous, as with a number of other comments in this section. This is due to the nature of the area, and such suggestions would need to be tested in further research.

Thirdly, the nurses may develop a negative attitude towards palliative care in nursing homes through misunderstandings of exactly what palliative care is. Misunderstandings about palliative care are not limited to the nurses, as residents and family members may also be confused as to what palliative care involves. A comment that "palliative care is often confused with

euthanasia" highlights the difficulty of the palliative care area. Some nurses may consider that they practise palliative care, which may not necessarily be the case. If nurses have an incorrect idea of palliative care, they may become disillusioned with the way that the patient and their family are being treated and cared for, and develop a negative attitude towards palliative care. Unless nurses have a thorough understanding of palliative care, the situation may become more difficult and confusing.

Byock (1994) suggested that nurses needed to demonstrate empathy with their patients, be compassionate and be willing to involve themselves emotionally with their patients and accept the personal risk that this may involve. Participants indicated that "palliative care needs a special type of carer". Perhaps not all nurses are prepared to develop a close relationship and become personally associated with the residents and their families. This unwillingness to take the risk of personal involvement may also contribute to the negative attitude towards palliative care. Statements such as "palliative care is worthless as treatment plan", "nurses get frustrated and stressed" and "staff need counselling during and after giving care", give some indication of the depth of belief in the concept. Emotional reactions such as "frustrated", "angry", and "annoyed" may indicate that nurses react emotionally as a result of an unpleasant experience. Nevertheless nurses also reported that this special carer does tend to receive positive emotional rewards and experience

personal growth as a result of their involvement in the care of the residents, as supported by emotional reactions such as “satisfying” and “empathy”.

The intensity both of the demands and the rewards that nurses get when practising palliative care may partly explain a notable feature of the data - its bimodality. Most nurses exhibited a definite attitude which was either positive or negative; few participants (2%) were neutral in their attitude. In the domain of palliative care, nurses are attending to people who are terminally ill and therefore, the nature of the area may be more demanding than others such as social groups and social policies. James (1993) mentions that “the emotional and psychological demands of palliative care are immense” (p. 8). For this reason participants might be expected to respond very strongly to palliative care, either negatively or positively. In the present sample, the nurses work daily with issues related to the attitude object, such as death and dying, even if they were not actually practising palliative care. It would be expected that these nurses would have a stronger attitude towards palliative care than an ordinary citizen might have towards a politician with whom they may have no contact or familiarity and who would not greatly affect their life. Similarly this argument could be applied to the area of social groups. Again these differences in the results are consistent with the suggestion that it is the domain of palliative care which may lead to the unique and different results.

A fifth area in which nurses responded concerned the effects of the multidisciplinary approach of palliative care. Palliative care involves the

cooperation of professionals from different disciplines, such as doctors, physicians, nurses, social workers, psychologists, occupational therapists and physiotherapists. However, it is the nurse that provides the ongoing care of the patient on a daily basis (Davies & Oberle, 1990). Participants acknowledged that palliative care was "multidisciplinary", that it was the "nurse's role to provide palliative care", that "palliative care needed professionals", and that "expert advice was needed for palliative care". Not only professionals, but also the role of the family was mentioned such as "wishes of the family and resident need to be paramount", and the "family need to be involved". Some nurses commented that often decisions are made without consulting the resident or the family by other members of the team such as the doctor.

In view of the recognition of the multidisciplinary approach and the role of the patient and family in palliative care, it may be expected that nurses are annoyed when they feel that the autonomy of the patient has been violated. It is very difficult to determine who should decide what is harmful or good for the patient. Palliative care operates from the view that the patient and family should decide treatment and care, together with the appropriate advice from the multidisciplinary team. This is consistent with the stated multidisciplinary approach of palliative care. However, if this does not occur and the patient and family are not consulted in the decision making process, some nurses may develop a negative attitude towards palliative care. A similar finding by

Blackburn (1989) suggested that adequate care of the terminally ill depended on satisfactory communication between patients, family and hospital staff. This proposition that it may have an influence on nurses' attitudes to palliative care would need to be tested in further research.

Nurses often develop a close relationship with patients as part of the practise of palliative care (Knepper, 1994). Staff counselling was an emotional issue to emerge and the following statements reflect the concern of the nurses, "staff need counselling during and after giving care" and "need for skills for grief counselling for residents and families". If this emotional attachment is part of caring in palliative care, this may account for why emotions independently and significantly predict the attitude as well as beliefs. Although there is no substantial evidence for this at present, this area of emotional involvement and identification could be investigated further.

Emotions appear to play a role when the nurses have to cope with the negative feelings and anger of the patients. Nurses have to deal with the emotions that have been aroused in them personally. Phrases such as nurses feel "stressed", and "powerless", provide tentative support for this suggestion. As Degner and Gow (1988) suggest nurses need to identify and recognise their own feelings and to preserve their own integrity in terms of their beliefs. Dealing with terminally ill patients and their family can be very emotionally demanding and it may be difficult not to get involved with the family after the

death of a patient. The suggestion that "staff need counselling during and after giving care" lends credence to this idea.

These are some of the beliefs and emotions generated by the attitude object "palliative care in nursing homes" which may account for the attitudes of nurses and may explain the difference between this and previous studies.

An examination of Table 5.21 indicates that the mean scores of beliefs and emotions are close to zero, and are all smaller than their associated standard deviations. The distribution of beliefs and emotions was bimodal which was similar to attitude. This indicates that in response to the attitude object "palliative care in nursing homes", some participants were able to generate strong beliefs and strong emotions.

Methodological considerations may explain differences between the present and previous study. In this research participants were required to generate their own beliefs and emotions in response to the attitude object "palliative care in nursing homes", using a method termed the free response methodology (Eagly, Mladinic & Otto, 1994). The participants in both the pilot and the main study appeared to have no difficulty in generating words and phrases in response to the attitude object "palliative care in nursing homes". Furthermore, examination of these responses revealed that they were all clearly distinguishable as cognitive or affective responses. Thus, the methodology was deemed successful with regard to this attitude object. Previous research by Eagly, Mladinic and Otto found that participants

generated more beliefs than emotions in the first part of their study using social groups as the attitude object, but there was no such difference when social policies was used as the attitude object. The results in the present study reflected the ability of participants to generate both beliefs ($n=57$) and emotions ($n=63$).

Breckler and Berman (1991) have argued that the free response methodology necessitates that participants generate beliefs and emotions and are then obliged to verbalise and write them down. Eagly, Mladinic and Otto (1994) responded to this criticism that the measure provided an indirect measure of affect and it may have been easier for participants to write down their beliefs than emotions. This may also account for why more beliefs than emotions were generated in their study.

Studies have considered not only beliefs, but also the role of affect in the formation of the attitude. Abelson, Kinder, Peters and Fiske (1982) required participants to use a checklist to denote personality traits to national politicians and the feelings these politicians elicited, and they found that affect was a better predictor of the attitude than beliefs. These results differed from the present study, where beliefs and emotions were both found to significantly and independently predict the attitude of nurses to palliative care in nursing homes. Differences in the methodologies which were used in the two studies may account for these differences in results. Eagly, Mladinic and Otto (1994) commented that the use of checklists and rating scales to distinguish between

cognitive and affective components of the attitude was unreliable. They further suggested that the standard list of responses generally reflects the overall attitude and not the emotions or feelings associated with the attitude object. Abelson et al. (1982) used checklists for beliefs and emotions whereas the present research used the free response methodology to generate beliefs and emotions. Furthermore, different attitude objects were used in the two studies: Abelson et al. used national politicians, whereas this study used attitudes of nurses to palliative care in nursing homes. Thirdly, the two samples were different: Abelson et al. used participants drawn nationally from the population in the United States, and in this study only nurses currently working in nursing homes in the Perth metropolitan region were randomly selected as participants.

As previously described, a study conducted by Eagly, Mladinic and Otto (1994) used the free response methodology to generate beliefs and emotions by the participants, firstly in response to four social groups (women, men, Democrats and Republicans). They found that beliefs was the most significant predictor of the attitude for women, men and Democrats whereas for Republicans beliefs and affects both significantly predicted the attitude. Secondly, they found that cognition was the better predictor for all the issues although affect was a marginally significant predictor of the attitude in two of three social issues they canvassed. Perhaps the difference in results between their study and the present thesis could be attributed to the use of different

samples (students and nurses) or the different attitude objects (social groups, social policies and palliative care in nursing homes). As they obtained similar results to the present study with Republicans as their attitude object, perhaps different attitude objects account for the difference in results, and therefore different attitudes may be based on different classes of information, cognitive or affective or both.

Many of the previous studies used checklists to obtain the cognitive and affective information. This difference in methodology among the different studies could help explain why results were different for each domain. The checklist methodology may result in participants being primed by the list. As Eagly, Mladinic and Otto (1994) have noted, there was no guarantee that participants have considered the applicability of the items on the checklist with respect to the attitude object prior to responding to the actual checklist. It was also possible that, because it was usually very difficult to elicit emotions, therefore when one attempted to do so, the emotions tended to become "cognitivised". This indicated that participants considered whether it was plausible that they would experience each of the emotions on the checklist, rather than imagining themselves in the situation and experiencing the emotions associated with it. In this study instructions indicated to the participants that they were to elicit their own emotions. This free response methodology allowed the participants to generate their own emotions to the attitude object "palliative care in nursing homes". This methodology, by

allowing participants to elicit their own emotions, may have been more successful, and therefore less cognitivising may have taken place.

In research on social groups and social policies, Eagly, Mladinic & Otto (1994) found that it was easier for participants to elicit beliefs than emotions in the first part of their research. As has been mentioned previously, participants had no difficulty generating beliefs and emotions to social policies. This was mirrored in the present research on attitudes of nurses to palliative care in nursing homes where participants experienced no difficulty in writing down their beliefs or emotions. In fact, a few more emotions ($n=63$) than beliefs ($n=57$) were given. The area of palliative care may be an emotional one where nurses are dealing with people who are terminally ill, and in caring for these patients they may form attachments to them and experience an emotional upheaval when the death of the patient occurs (McWilliam, Burdock & Wamsley, 1993). In view of the emotions which may be generated by the area, it was not surprising that participants had no trouble eliciting emotions.

There was also no evidence to suggest that those nurses with strong beliefs also possessed only strong emotions. The results suggested that there was a moderate correlation between beliefs and emotions $r(226) = .43$, $p < .001$. Although beliefs and emotions were significantly correlated, they still independently and significantly predicted the attitude. There could be numerous explanations for this significant correlation. It could be that beliefs

lead to the emotions, or that emotions lead to the beliefs, or there could be a third unknown factor which is responsible for both beliefs and emotions.

Another possibility for this result could be that both beliefs and emotions were both measuring evaluation and therefore they would both have yielded similar results. Perhaps they were not measuring distinctly separate components.

There is a debate in the literature and Breckler (1984) suggested that affect and evaluation (cognition) were distinct components in the structure of attitudes, whereas Zajonc (1980) proposed that affect and cognition were controlled by separate and "partially independent" systems (p.151) which may be connected or quite independent of each other. This is tentative and needs to be examined further in future studies to determine the underlying connection between beliefs and emotions.

In summary the difference in results could be due to the attitude object used. Also the free response methodology allowed easier access to the emotions of the participants. The sample in the present study was mainly female which may have had some effect on the results.

6.2 The contribution of knowledge to attitudes to palliative care

A further research question asked whether knowledge predicted the attitudes of nurses to palliative care in nursing homes after beliefs and emotions had been taken into account. As the need for palliative care increases, so does the need for palliative care education (James, 1993). Copp

(1994) suggested that there was a need to determine the most appropriate way for nurses to learn the required knowledge and skills of palliative care. She recommended that nurses learn about therapeutics, how to respond to and handle patients especially when the beliefs and values of the nurses were challenged, and how to cope with the situation when the patient was dying. These arguments were reflected in one of the beliefs listed in this study, "the need for education". If the nurse does not feel competent to carry out the functions of palliative care, such as different therapies and psychological care, this may lead to a negative attitude towards palliative care.

An interesting finding was the relationship between the knowledge items and the beliefs generated by the participants. On examination of the beliefs, it was found that many of them accurately reflected the knowledge items. For example, the fact that palliative care was "multidisciplinary", "family needs to be involved", "palliative care considers psychological needs" and "palliative care considers spiritual needs". Despite this accuracy of the beliefs generated by the participants, the correlation between beliefs and knowledge for all the participants though significant ($r = .29, p < .001$), was smaller than the correlation between emotions and knowledge ($r = .39, p < .001$). This is an interesting finding as one would have expected beliefs to be at least as strongly related to knowledge as emotions considering the types of beliefs that were generated and their accuracy with the knowledge items according to the definition used of palliative care in this research (see section

1.2). Furthermore, for the directors of nursing and clinical nurse specialists, the correlation between beliefs and knowledge ($r = .12$, $p > .05$) was not significant, and also very low - which is surprising considering that knowledge added significantly to the prediction of the attitude for this group, and they had the highest mean knowledge score of the three groups.

The technical expertise required in palliative care and the resources available have become so abundant that this may make the nurse feel unskilled and unable to keep up with the knowledge explosion. This view was supported by the statement "need education". However, the results also indicated that even if these nurses were given the opportunity to acquire the necessary knowledge and skills to carry out palliative care, this would not necessarily ensure a positive attitude. One may speculate that in the training of nurses, the practical application of palliative care needs to be emphasised and developed in the future. Even after their initial training, a form of postgraduate training may need to be available whereby nurses are able to learn new techniques and further develop their skills and knowledge about the area.

On the other hand a salient finding was that education made no difference to the attitude of the nurses. It would appear that within the present training program, nurses are not adequately prepared for the complex situations that may arise in palliative care, such as problems in communication between multidisciplinary team members, decisions about type of treatment,

prognosis, life expectancy, and whether to engage in active treatment and clinical knowledge about palliative care, which was supported by McWilliam, Burdock and Wamsley (1993) and Degner and Gow (1988). As Sneddon (1991) suggested, it is now recognised that one has to impart this knowledge to the nurses. The problem arises how to accomplish this. But the results of this study fail to provide evidence that imparting such knowledge will affect attitudes of nurses to palliative care.

Furthermore, this present study found that knowledge did not significantly predict the attitude of registered nurses (which is the largest group working in the nursing homes). Perhaps it was not only the knowledge that needed to be examined, but the way this knowledge was acquired. Possibly the undergraduate curriculum provides too little time for teaching about palliative care. Only 21% of registered nurses reported receiving any education about palliative care in their undergraduate course (12% in postgraduate). This may have implications for the training programs currently being undertaken and warrants further attention.

Currently there is little exposure of nurses during training to practical palliative care units. Nurses may develop negative attitudes to palliative care if they were not exposed to practical work in a palliative care situation and were unaware of how the patient was treated within palliative care. Some evidence for this comes from this study which found that those nurses who were currently practising palliative care were more likely to have a positive

attitude than those who were not. This reflected Copp's (1994) distinction between the knowledge that the nurses' possess and the practical knowledge which they have gained through experience. She argued that it was important that nurses have the opportunity to learn from experienced nurses. This would also provide the possibility for nurses to discuss their feelings and problems with each other and with experienced personnel in the field. The participants in the study mentioned this in comments such as "staff need counselling during and after giving care" and they required "skills needed for grief counselling for residents and for families". Sneddon (1991) suggested that, in addition to the knowledge and skills needed to practise palliative care, nurses required skills in communication and how to cope with the spiritual needs of the residents. Participants described this in comments like "communication is the basis of palliative care", "need for education", "needs support from peers". The implication was that positive peer support may help reduce stress. As Benoliel (1988) suggested, it was not only the knowledge that the nurses learned during their training that was important, but regular support for the nurse needs to be taken into account.

Furthermore, the knowledge questions did not include any practical medical type questions. Perhaps these need to be included to gain a broader base of knowledge questions. A problem arises because, if these questions are included, some method must be employed whereby the participants do not go to a reference book to access the answers to these questions. Questionnaires

would have to be administered by a researcher and not be self administered. These types of questions were deliberately avoided in this study for this reason. In this study, the knowledge section determined whether the nurses had an understanding of palliative care and the basic principles of palliative care: for example that palliative care was multidisciplinary and viewed the patient and family as one unit. This study provided no evidence that knowledge, as so defined, was required to encourage a positive attitude to palliative care. Another possible explanation for knowledge being less strongly related to attitudes than beliefs and emotions, was that a different measurement was used to obtain the knowledge score than was used to score the emotions and beliefs. For beliefs and emotions, participants were required to first generate their own beliefs and emotions, and then rate them as to what extent the belief or emotion affected their attitude to palliative care. For the knowledge section, a series of statements were presented to the participants with which they were required to agree or disagree. This difference in technique may account for these results.

As mentioned previously, the results of the relationship between knowledge and the attitude differed for the three groups of participants. For the directors of nursing and clinical nurse specialists, the regression showed that knowledge significantly added to the prediction of the attitude beyond beliefs and emotions. This group also had a higher knowledge score ($M=86.66$) than the registered nurses ($M=83.57$) and nursing assistants

($M=79.47$). It was not surprising that the directors of nursing and clinical nurse specialists had more knowledge than the other nurses, since they were also the group that have the responsibility for administration within the nursing home and decision making. In view of these factors, it is perhaps appropriate that their attitude to palliative care is significantly related to their knowledge of the principles underlying palliative care. For the registered nurses and nursing assistants there was no significant independent association between knowledge and attitude.

Nurses gain certain knowledge and information through educational training programs. Perhaps it is not education per se, but the type of education that is inadequate. Further research could undertake a detailed examination of the type of education that nurses receive.

6.3 Behaviour and attitude of nurses to palliative care in nursing homes

As mentioned previously, this study did not set out to measure behaviour as a component of Zanna and Reimpel's (1988) model, but the demographic data provided two rough measures of behaviour, namely: whether participants had previously practised palliative care and whether participants were currently practising palliative care. The results indicated that there was no relationship between the attitude to palliative care and whether or not nurses had previously worked in palliative care. As with some of the other results, it may be the nature of the area (i.e., palliative care) which influenced

these results. These nurses worked in the area where they were dealing with death and dying and may make an unconscious decision to switch off from it once they had left the domain.

However, those nurses who were currently practising palliative care were more likely to have a positive attitude than those who were not. Interestingly it appears that nurses need to be actually doing "hands-on" practice of palliative care and seeing its effect, as there was no association with attitude. Possibly nurses forget the benefits of palliative care if they do not practise it - though it hardly seems likely that a nurse could forget all the benefits of practising palliative care on people who are terminally ill. Perhaps a more likely explanation of these results is that palliative care is constantly changing. As discussed earlier, there are changes in technology and society with an emphasis on the right to life and to keep patients alive at all costs (Benoliel, 1988). If nurses were satisfied with the palliative care situation 20 years ago, this may not mean they will accept similar treatment today.

It is also possible there may be a misunderstanding by some nurses of what palliative care is presently all about. The type of work that the different groups of nurses practise in the nursing home, may also affect their attitude towards palliative care. The directors of nursing who mainly do administrative work and are not involved in the actual caring for the patients, and the clinical nurse specialists, who do both administrative work and have some contact with the patients, were no more likely to have a positive attitude to palliative care in

nursing homes even if it was currently being practised in their nursing homes. Most of the caring and contact with the patients is by the registered nurses and nursing assistants who have no administrative responsibility. It may be that the nurses have a different attitude towards palliative care depending on their involvement with the residents in the nursing home.

Medical technology and expertise is constantly changing, due to the advancement and progress in medicine. Medical specialisation has developed to such an extent that it has contributed to this type of health care delivery where the patients tend to feel alienated within this system. Ventafridda (1988) supports this view that presently the tendency is to "prolong life at any cost, the importance of objective, clinical data, and the disease as an entity which must be fought are fundamental aspects of the existing education" (p. 15). Nurses are trained within this system and may internalise these values which they have experienced during their training. These values could contribute to a negative attitude towards palliative care, their attitude towards the patients and the type of medical practice of which they want to be a part.

6.4 Practical Implications

1. The results suggest that beliefs and emotions be taken into account if there is a need to change the attitudes of nurses.
2. In so far as education is used, the results suggest that imparting knowledge only about palliative care to nurses may not change their attitudes

to palliative care in nursing homes. Education may need to address both the beliefs and emotions of nurses.

3. From this study, it is the current practice of palliative care that distinguishes the attitudes of nurses to palliative care. Future training programs could consider that practical experience in palliative care may be useful for nurses.
4. Palliative care requires nurses to form a close relationship with the patients. Facilities could be implemented for debriefing and providing counselling for the nurses during the provision of palliative care and after the death of a patient.
5. The information attained from nurses in this study about the attitudes of nurses to palliative care in nursing homes could be incorporated into the development of future plans for implementing palliative care to provide support and assistance to the nurses working in the area. Counselling services and peer support need to be made available formally for the nurses working in palliative care.
6. The results from this research have been requested by the WA Hospice Palliative Care Association in their effort to improve palliative care services in nursing homes.

6.5 Research Implications

Since psychological research in the palliative care area is very sparse, there are many studies which could be undertaken. From this study six possible areas of future research are:

1. A study could be undertaken to determine which class of information is the best predictor of the attitude for palliative care in nursing homes for the general population. Even though nurses have the most contact and care for the people who are terminally ill, it is important to determine societal attitudes towards palliative care in nursing homes. As palliative care is multidisciplinary, other role groups including both hospital based doctors and general practitioners, social workers and psychologists should also be included in the research to determine the attitudes of these different groups.
2. The present study found that beliefs and emotions independently and significantly predicted the attitude of nurses to palliative care in nursing homes. A further result indicated a significant correlation between beliefs and emotions. A future study could examine the link between beliefs and emotions to try and determine the relationship between them. This would establish whether the present results are an artefact of the area of palliative care or whether this result could be replicated in other areas.
3. A longitudinal study could be undertaken whereby the beliefs and emotions of the nurses are measured when the nurses enter the nursing home

and during intervals over a period of time. These results could be compared to a similar group of nurses who are not practising palliative care.

4. The methodology had already been successfully used in the areas of social groups and social policies, and could be deemed successful in the domain of palliative care. Its applicability to other areas could be tested further.

5. This study used mainly women as participants in the research. The issue of gender may have impacted on the results and this could be tested further.

6. As palliative care is multidisciplinary, there needs to be a cooperative working relationship between doctors, nurses and other health care professionals. Further insight could be developed into the different perceptions of nurses and doctors.

6.6 Conclusion

This study provided a test of the attitude model proposed by Zanna and Rempel (1988) in a different domain. The research has established that both cognitive and affective information both significantly and independently predicted the attitude of nurses to palliative care in nursing homes. If palliative care is to become an accepted form of health care, then the attitudes of those responsible for its implementation need to be addressed. The results of this study indicated that both the beliefs and emotions of the nurses need to

be taken into account. Furthermore, participants indicated a strong attitude towards palliative care in nursing homes, which was either positive or negative, with only a few participants indicating a neutral attitude. It appears that palliative care is an emotional area and for the successful implementation of palliative care, careful attention needs to be paid not only to beliefs but to the emotions of the nurses working in the area. Those involved in the implementation of palliative care should not ignore the emotions of the nurses. The free response methodology was deemed successful in the area of palliative care, and the participants had no trouble generating beliefs and emotions in response to the attitude object.

There was a significant correlation between knowledge and attitude for all the nurses, so that the greater the knowledge of the nurses, the more positive the attitude. However, for the registered nurses and nursing assistants, knowledge did not contribute significantly to the attitude after beliefs and emotions had been taken into account. Furthermore, it was the current practice of palliative care that distinguishes the attitude of nurses to palliative care in nursing homes. Therefore, it may be important in future research and practice to consider the practical experience of palliative care by the nurses in the future.

Palliative care is as much an attitude as it is possessing the knowledge and skills of how to carry it out. It is caring for the person who is terminally ill sensitively, using a multidisciplinary approach and involving both the

patient and family. The nurse is required to engage with the patient and family with open communication and a respect for everyone who is involved. There appears to be an emphasis on education of the nurses in palliative care in the literature. Perhaps it is not the amount of education that needs to be addressed, but the kind of education that the nurses receive which needs to be investigated. Although this is all part of palliative care, if the delivery of palliative care is to be effective and available to all who require it, these central issues need to be conveyed to all nurses.

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APPENDIX A

Pilot Study Questionnaire

QUESTIONNAIRE ON PALLIATIVE CARE IN NURSING HOMES



Thank you for volunteering to complete the attached questionnaire. I am a Master of Psychology student at Edith Cowan University, conducting this study for my thesis. The attached questionnaire is to be used in the study to find out nurses' understanding and feelings about palliative care.

Confidentiality will be maintained at all times and no names and addresses are required. You are free to withdraw at any time and need not complete any part of the questionnaire. Information supplied will only be used for this research. I would be very grateful for any feedback on the questionnaire that would assist me with the final draft.

My name is LYNNE COHEN and I can be contacted on 276-3376, my supervisors for the thesis are Dr Moira O'Connor who can be contacted on 405-5593 and Dr Amanda Blackmore who can be contacted on 400-5529.

Please complete all FIVE sections of the questionnaire and read the instructions carefully for each section. All sections should be completed in the order in which they are presented.

SECTION 1

Please circle the number that corresponds with your personal view point of palliative care in nursing homes.

Category 1 represents the strongest view of palliative care in nursing homes.

Category 7 represents the weakest view of palliative care in nursing homes.

Category 4 represents the neutral part of the scale.

Palliative care in nursing homes is

Favourable	1	2	3	4	5	6	7	Unfavourable
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SECTION 3

Please list briefly **up to 10 emotions** that you **feel** in relation to palliative care in nursing homes. Next to each emotion please rate whether each is favourable or unfavourable to Palliative Care in nursing homes on the scale provided.

-3 represents the most unfavourable feelings of palliative care in nursing homes.

3 represents the most favourable feelings of palliative care in nursing homes.

0 represents the neutral part of the scale.

Emotions (Please list up to 10)	Unfavourable				Favourable		
	-3	-2	-1	0	1	2	3
_____	-3	-2	-1	0	1	2	3
_____	-3	-2	-1	0	1	2	3
_____	-3	-2	-1	0	1	2	3
_____	-3	-2	-1	0	1	2	3
_____	-3	-2	-1	0	1	2	3
_____	-3	-2	-1	0	1	2	3
_____	-3	-2	-1	0	1	2	3
_____	-3	-2	-1	0	1	2	3
_____	-3	-2	-1	0	1	2	3
_____	-3	-2	-1	0	1	2	3

SECTION 4

The following is a collection of statements. Please read each one and decide *whether it describes palliative care in nursing homes*. Please indicate your decision with a TICK in the appropriate box.

1. Nurses help the patient's family identify ways of coping.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

2. Nurses shield the family from the unpleasant aspects of the disease.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

3. Nurses are aware of other stresses the family has to cope with besides the patient's illness.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

4. Nurses do not have to be part of a multidisciplinary palliative care team.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

5. Nurses have strategies to distract the patient from their pain.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

6. Nurses talk to the family about the resident in front of him or her.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

7. Nurses administer life-saving interventions whenever they are available.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

8. Nurses make themselves known to the patient's family.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

9. Nurses provide only as much information as the patient wants to hear.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

10. Nurses spend time listening to the patient whenever their other duties permit.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

11. A multidisciplinary team consults with the resident and family to make *all* decisions about long-term resident care.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

12. Nurses are primarily concerned with residents' physical symptoms.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

13. Nurses always include families in treatment and care discussions and decisions.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

14. Nurses direct residents and families to a doctor when they ask about the effectiveness of various interventions.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

15. In instances where a resident wants an analgesic before it is due, the nurse consults a doctor before administering it.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

16. Nurses set aside certain times to be available to families who need information.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

17. Nurses inform the family of changes in the patient's medications and give reasons why.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

18. It is nurses' responsibility to ensure that spiritual support is made available to patients.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

19. Nurses avoid issues relating to death when talking to patients.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

20. Analgesics are always given strictly according to the prescribed schedule.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

21. The nurse explains signs of approaching death to the family where appropriate.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

SECTION 5

The following questions require information about you.

Please tick the appropriate box.

1. Are you: Male ☐ Female ☐

2. What age are you ? _____

3. Please indicate whether you are a:

☐ ☐ ☐ ☐ ☐ ☐

Director of Nursing	Clinical Nurse Specialist	Registered Nurse	Enrolled Nurse	Nursing Assistant	Other
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4. How long have you been a practising nurse/nursing assistant? _____

5. How long have you worked at the nursing home? _____

6. Have you previously worked in a palliative care setting? ☐ YES ☐ NO

7. Are you currently practising palliative care? ☐ YES ☐ NO

8. Have you ever personally been involved with a close family member or close friend in a dying situation? ☐ YES ☐ NO

9. Did you receive formal education on palliative care in an undergraduate course? ☐ YES ☐ NO

10. Did you receive formal education on palliative care in a postgraduate course? ☐ YES ☐ NO

11. Have you participated in any ongoing professional training in palliative care in the form of workshops or seminars? ☐ YES ☐ NO

If so, please specify _____

12. Please indicate which other areas of nursing you have worked in:

community ☐

paediatric ☐

acute care ☐

geriatric ☐

psychiatric ☐

other (please specify) ☐

Please comment briefly on the questionnaire by answering the following questions:

1. Were any of the questions difficult to answer? If so, could you please explain why.

2. Please comment on the questionnaire in general. Your ideas will greatly assist with the final questionnaire.

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE.

APPENDIX B

Front Page Cover of Pilot Questionnaire

Information for Potential Participants

Dear participant,

I am currently doing a Master of Psychology degree at Edith Cowan University. My research is designed to find out what are the attitudes of nurses to palliative care in nursing homes in the Perth Metropolitan Region. Presently I am ready to pilot the questionnaire and I would be very grateful if you would help by completing it on two separate occasions and then returning them to me at the Joondalup Campus by Friday 23 June 1995.

Taking part in this study is entirely voluntary. You do not have to leave your name and address and you do not have to fill out anything that you do not wish to.

If you have any queries, please feel free to ring me (Lynne Cohen) on 276 3376 or either of my supervisors: Dr Moira O'Connor on 400 5593 or Dr Amanda Blackmore on 400 5529.

Thanking you in anticipation for you help.

Lynne Cohen

APPENDIX C

Main Study Questionnaire

QUESTIONNAIRE ON PALLIATIVE CARE IN NURSING HOMES



Thank you for volunteering to complete the attached questionnaire. I am a Master of Psychology student at Edith Cowan University, conducting this study for my thesis. The attached questionnaire is to be used in the study to find out nurses' understanding and feelings about palliative care.

Confidentiality will be maintained at all times and no names and addresses are required. You are free to withdraw at any time and need not complete any part of the questionnaire. Information supplied will only be used for this research.

My name is LYNNE COHEN and I can be contacted on 276-3376, my supervisors for the thesis are Dr Moira O'Connor who can be contacted on 405-5593 and Dr Amanda Blackmore who can be contacted on 400-5529.

Please complete all FIVE sections of the questionnaire and read the instructions carefully for each section. All sections should be completed in the order in which they are presented. (If you need extra space, please insert extra pages).

SECTION 1

1. Please circle the number that corresponds with your personal view point of palliative care in nursing homes.

Category 1 represents the weakest view of palliative care in nursing homes.

Category 7 represents the strongest view of palliative care in nursing homes.

Category 4 represents the neutral part of the scale.

Palliative care in nursing homes is

Unfavourable 1 2 3 4 5 6 7 Favourable

SECTION 2

INSTRUCTIONS

In this section, you will be asked to list briefly **up to 10 beliefs** that you personally have about palliative care in nursing homes or the effects of palliative care in nursing homes. For example, you probably have some beliefs about the effects that palliative care is likely to have. You might also have some beliefs about who supports palliative care or about the likelihood that palliative care will be implemented.

Just think about palliative care for a few seconds, and then write down whatever you think is true about palliative care. Write one thought in each box that will be provided. Please write down **up to 10** of your beliefs about palliative care.

Next to each belief please rate whether each is favourable or unfavourable to Palliative Care in nursing homes on the scale provided.

-3 represents the most unfavourable beliefs of palliative care in nursing homes.

3 represents the most favourable beliefs of palliative care in nursing homes.

0 represents the neutral part of the scale.

There now follows a couple of examples.

For example:

For the issue **logging in natural forests**, several boxes would appear, such as the following:

I believe	Unfavourable						Favourable
	-3	-2	-1	0	1	2	3

In the first box, you might write "it would destroy all the natural forests". It is likely that this statement would make you opposed to allowing logging in natural forests. Therefore you would circle the **-3** at the **unfavourable** end of the scale. There are of course no right or wrong answers. You merely write down what you personally believe is true about logging in natural forests

I believe	Unfavourable						Favourable
	-3	-2	-1	0	1	2	3

In the second box, you might write "it provides much needed wood". It is likely that this statement would make you in favour of allowing logging in natural forests. Therefore you would circle the **3** at the **favourable** end of the scale. There are of course no right or wrong answers. You merely write down what you personally believe is true about logging in natural forests.

NOW DO THIS TASK FOR PALLIATIVE CARE IN NURSING HOMES ON THE NEXT PAGE

Palliative Care in Nursing Homes

Please list up to 10 beliefs. (You do not have to fill in all 10 boxes)

1.

I believe

Unfavourable

-3 -2 -1 0 1 2 3

Favourable

2.

I believe

Unfavourable

-3 -2 -1 0 1 2 3

Favourable

3.

I believe

Unfavourable

-3 -2 -1 0 1 2 3

Favourable

4.

I believe

Unfavourable

-3 -2 -1 0 1 2 3

Favourable

5.

I believe

Unfavourable

-3 -2 -1 0 1 2 3

Favourable

6.

I believe

Unfavourable

Favourable

-3 -2 -1 0 1 2 3

7.

I believe

Unfavourable

Favourable

-3 -2 -1 0 1 2 3

8.

I believe

Unfavourable

Favourable

-3 -2 -1 0 1 2 3

9.

I believe

Unfavourable

Favourable

-3 -2 -1 0 1 2 3

10.

I believe

Unfavourable

Favourable

-3 -2 -1 0 1 2 3

SECTION 3

The following questions require information about you.

Please tick the appropriate box.

1. Are you: Male ☐ Female ☐
2. What age are you? _____
3. Please indicate whether you are a:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Director of Nursing	Clinical Nurse Specialist	Registered Nurse	Enrolled Nurse	Nursing Assistant	Other
4. How long have you been a practising nurse/nursing assistant? _____
5. How long have you worked at the nursing home? _____
6. Have you previously worked in a palliative care setting?

<input type="checkbox"/>	<input type="checkbox"/>
YES	NO
7. Are you currently practising palliative care?

<input type="checkbox"/>	<input type="checkbox"/>
YES	NO
8. Have you ever personally been involved with a close family member or close friend in a dying situation?

<input type="checkbox"/>	<input type="checkbox"/>
YES	NO
9. Did you receive formal education on palliative care in an undergraduate course?

<input type="checkbox"/>	<input type="checkbox"/>
YES	NO
10. Did you receive formal education on palliative care in a postgraduate course?

<input type="checkbox"/>	<input type="checkbox"/>
YES	NO
11. Have you participated in any ongoing professional training in palliative care in the form of workshops or seminars?

<input type="checkbox"/>	<input type="checkbox"/>
YES	NO

If so, please specify _____

12. Please indicate which other areas of nursing you have worked in:

community ☐

paediatric ☐

acute care ☐

geriatric ☐

psychiatric ☐

other (please specify) ☐

SECTION 4

INSTRUCTIONS

Now I am interested in your personal reactions to palliative care. In this section, you will be asked to list briefly **up to 10 emotions** that you **experience** in relation to palliative care in nursing homes. By emotions I mean the feelings that you have when you think about or talk about palliative care in nursing homes. Below the issue of palliative care in nursing homes, several boxes will appear. Write one emotion in each box that will be provided. These emotions may be pleasant or unpleasant. Please write down all of the emotions that you typically feel in relation to palliative care in nursing homes.

Next to each emotion please rate whether each is favourable or unfavourable to Palliative Care in nursing homes on the scale provided.

-3 represents the most unfavourable feelings of palliative care in nursing homes.

3 represents the most favourable feelings of palliative care in nursing homes.

0 represents the neutral part of the scale.

There now follows a couple of examples.

For example:

For the issue on whether whaling should be allowed to continue, several boxes will appear such as the following:

Makes me feel

Unfavourable

Favourable

-3 -2 -1 0 1 2 3

In the first box, you might write the word "angry". It is likely that this statement would make you opposed to allowing whaling to continue. Therefore you would circle the -3 at the unfavourable end of the scale. There are of course no right or wrong answers. You would merely write down the emotions that you typically experience in relation to this issue. If you wonder whether something is an emotion, just see if it fits the phrase, "makes me feel.....".

Makes me feel

Unfavourable

Favourable

-3 -2 -1 0 1 2 3

In the second box, you might write the word "excitement". It is likely that this statement would make you in favour of allowing whaling to continue. Therefore you would circle 2 at the favourable end of the scale. There are of course no right or wrong answers. You would merely write down the emotions that you typically experience in relation to this issue. If you wonder whether something is an emotion, just see if it fits the phrase, "makes me feel.....".

NOW DO THIS TASK FOR PALLIATIVE CARE IN NURSING HOMES ON THE NEXT PAGE

Palliative Care in Nursing Homes

Please list up to 10 emotions.
(You do not have to fill in all 10 boxes)

1.

Makes me feel

Unfavourable

Favourable

-3 -2 -1 0 1 2 3

2.

Makes me feel

Unfavourable

Favourable

-3 -2 -1 0 1 2 3

3.

Makes me feel

Unfavourable

Favourable

-3 -2 -1 0 1 2 3

4.

Makes me feel

Unfavourable

Favourable

-3 -2 -1 0 1 2 3

5.

Makes me feel

Unfavourable

Favourable

-3 -2 -1 0 1 2 3

6.

Makes me feel

Unfavourable

-3 -2 -1 0 1 2 3

Favourable

7.

Makes me feel

Unfavourable

-3 -2 -1 0 1 2 3

Favourable

8.

Makes me feel

Unfavourable

-3 -2 -1 0 1 2 3

Favourable

9.

Makes me feel

Unfavourable

-3 -2 -1 0 1 2 3

Favourable

10.

Makes me feel

Unfavourable

-3 -2 -1 0 1 2 3

Favourable

SECTION 5

The following is a collection of statements. Please read each one and decide *whether it describes palliative care in nursing homes*. Please indicate your decision with a TICK in the appropriate box.

1. Nurses help the patient's family identify ways of coping.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

2. Nurses refrain from discussing the unpleasant aspects of the disease with the family.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

3. Nurses are aware of other stresses the family has to cope with besides the patient's illness.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

4. Nurses do not have to be part of a multidisciplinary palliative care team.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

5. Nurses make themselves known to the patient's family.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

6. Nurses have strategies to distract the patient from their pain.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

7. Nurses talk to the family about the resident in front of him or her.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

8. Nurses constantly check to determine how much information the patient wishes to know and provides only that information to patients.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

9. A multidisciplinary team consults with the resident and family to make *all* decisions about long-term resident care.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

10. Nurses are primarily concerned with residents' physical symptoms.

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

11. Nurses always include families in treatment and care discussions and decisions.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

12. Nurses direct residents and families to a doctor when they ask about the effectiveness of various interventions.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

13. In instances where a resident wants an analgesic before it is due, the nurse consults a doctor before administering it.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

14. Nurses inform the family of changes in the patient's medications and give reasons why.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

15. It is nurses' responsibility to ensure that spiritual support is made available to patients.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

16. Nurses avoid issues relating to death when talking to patients.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

17. Analgesics are always given strictly according to the prescribed schedule.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

18. The nurse explains signs of approaching death to the family where appropriate.

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly agree	Agree	Slightly agree	Undecided	Slightly disagree	Disagree	Strongly disagree

**THANK YOU FOR TAKING THE TIME TO COMPLETE THIS
QUESTIONNAIRE**

APPENDIX D

Front Page Cover of Main Study Questionnaire

Information for Potential Participants

Dear participant,

I am currently doing a Master of Psychology degree at Edith Cowan University. My research is designed to find out what are the attitudes of nurses to palliative care in nursing homes in the Perth Metropolitan Region. I would be very grateful if you would fill in the questionnaire which is attached to this letter.

Taking part in this study is entirely voluntary. You do not have to leave your name and address and you do not have to fill out anything that you do not wish to.

This is the first major study on attitudes in the area of palliative care. All the information collected will be used for my thesis, and hopefully will be useful for your profession in the future. I have been working closely with the Western Australian Research Committee on Palliative Care, and I hope that this information will be valuable to them and to nurses in general.

If you have any queries, please feel free to ring me (Lynne Cohen) on 276 3376 or either of my supervisors: Dr Moira O'Connor on 400 5593 or Dr Amanda Blackmore on 400 5529.

Thank you very much for your time and effort.



Lynne Cohen

APPENDIX E

Letter to All Nurses from the W A Hospice Palliative Care Association Research Group



"Sharing in Caring"

W.A. Hospice Palliative Care Association (Inc.) Research Group

Dear

We are writing to introduce Mrs Lyne Cohen. Mrs Cohen is currently enrolled in a Master of Psychology degree at Edith Cowan University and is researching palliative care in nursing homes in the Perth metropolitan area as part of her masters course.

This research is one of many being undertaken by the West Australian Hospice Palliative Care Association Research Group in collaboration with Edith Cowan University.

Would you please lend your support to Mrs Cohen to enable her to undertake this research as the findings will contribute significantly to the ongoing provision of palliative care in nursing homes.

Thank you in anticipation.


Yours sincerely

LYNN OLDHAM
CLINICAL NURSE CONSULTANT
East Metropolitan Palliative Care Agency

DR AMANDA BLACKMORE
SUPERVISOR
Edith Cowan University


APPENDIX F

Letter to All Participants explaining the Nature of the Study


Western Australia
12 July 1995

Dear

My name is Lynne Cohen. As has been explained in the accompanying letter, I am conducting research into the attitudes of nurses to palliative care in nursing homes in the Perth metropolitan area. I have enclosed copies of the questionnaire. I would be very grateful if you as the Director of nursing, as well as the Clinical nurse specialist, the Registered nurses, Enrolled nurses and Nursing assistants working in your nursing home could please complete the questionnaires. I have also provided an envelope for each questionnaire to be placed in after completion which will ensure complete confidentiality of all questionnaires. Once these have been completed, I have provided a large envelope, addressed and stamped, for the completed questionnaires to be mailed back to me. I would be grateful if as many nurses as possible who work in your nursing home could fill in the questionnaire as soon as possible. I would appreciate it if they could be returned by the 25th July 1995.

If you require any further information or extra questionnaires, please do not hesitate to contact me on (09) 

Thanking you in anticipation

Lynne Cohen

APPENDIX G

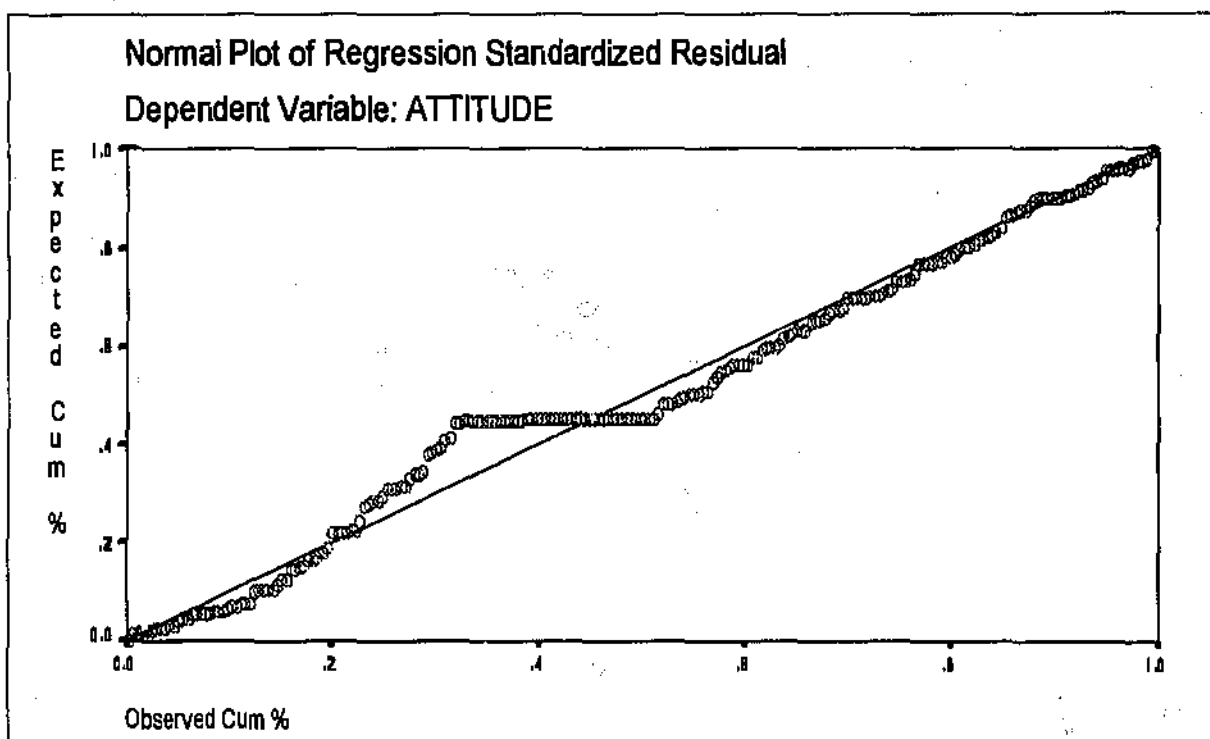
Coding Sheet for Knowledge Section of the Questionnaire

Data Scoring Details for Knowledge Questions of Section 5

Item Number	Range	
	Strongly agree	to Strongly disagree
1.	7	1
2.	1	7
3.	7	1
4.	1	7
5.	7	1
6.	7	1
7.	7	1
8.	7	1
9.	7	1
10.	1	7
11.	7	1
12.	1	7
13.	1	7
14.	7	1
15.	7	1
16.	1	7
17.	1	7
18.	7	1

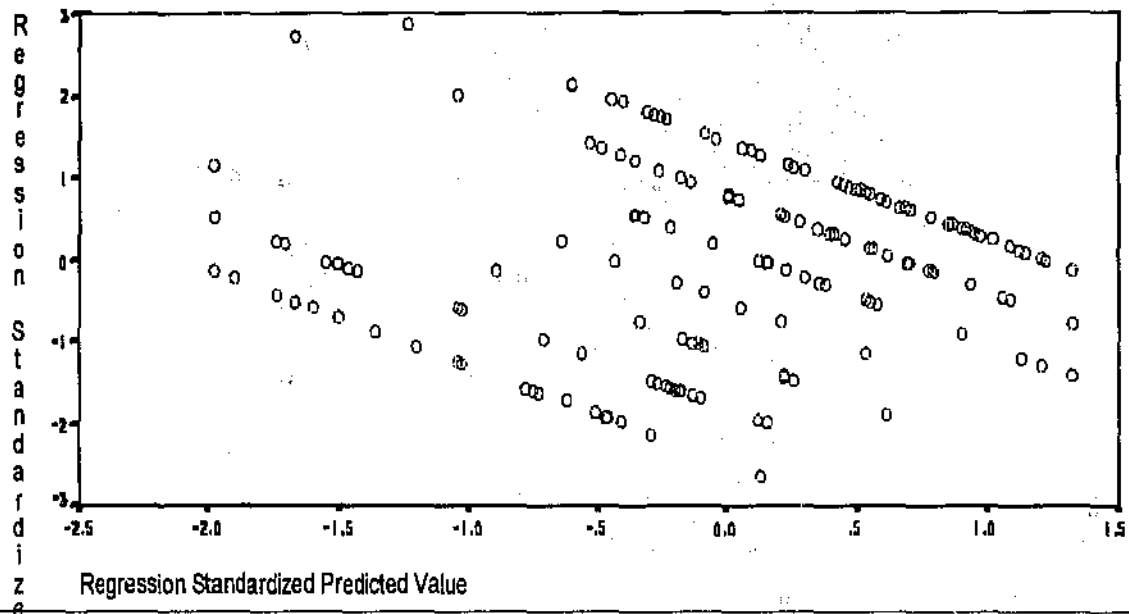
APPENDIX H

Residual Scatterplots



Scatterplot

Dependent Variable: ATTITUDE

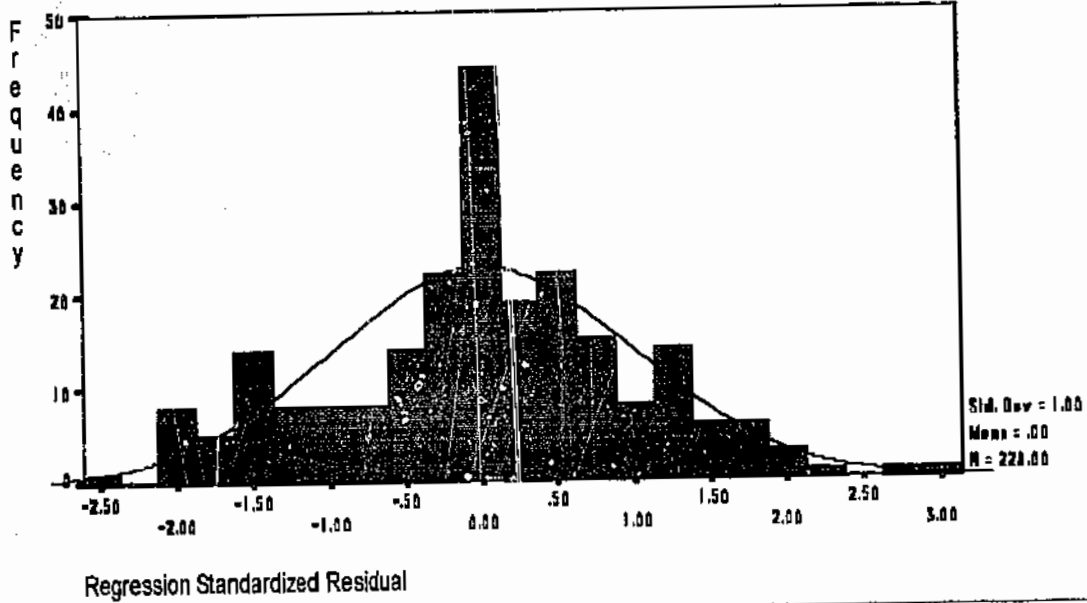


APPENDIX I

Histogram of Standardised Residuals

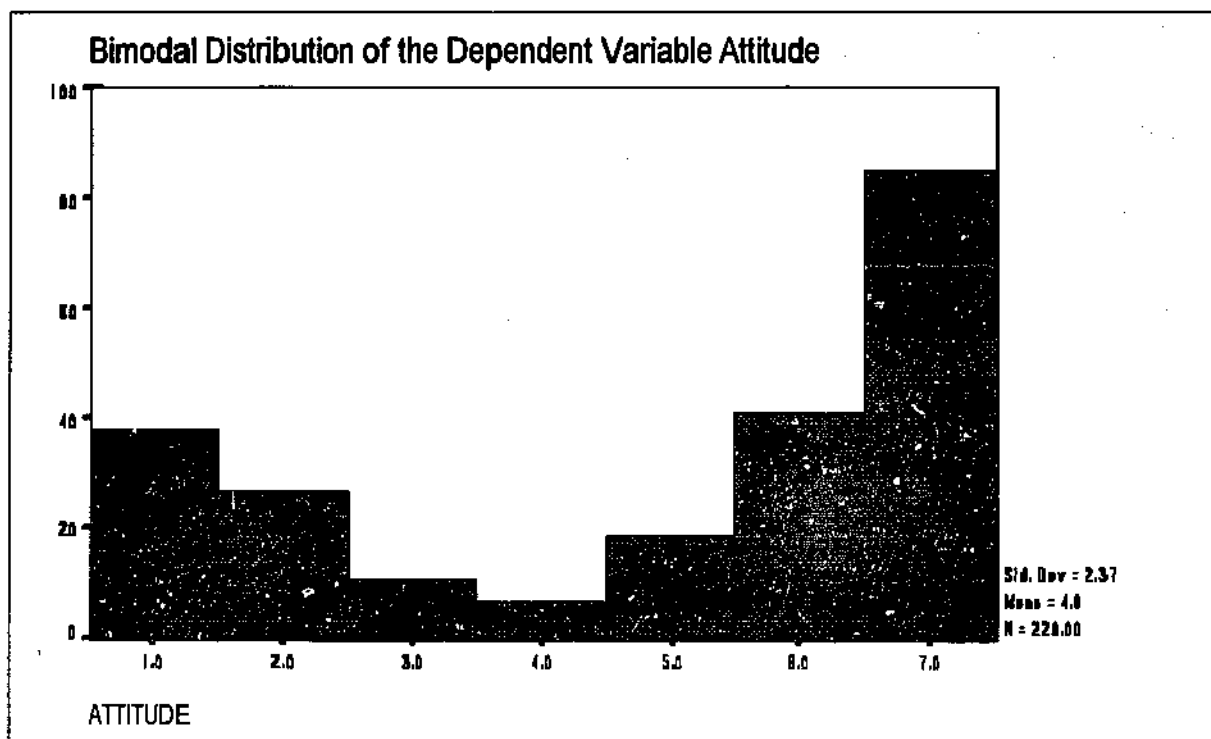
Histogram

Dependent Variable: ATTITUDE



APPENDIX J

Bimodal Distribution of the Dependent Variable Attitude to Palliative Care in Nursing Homes



APPENDIX K

List of Beliefs and Emotions generated by the Participants

Summary of Beliefs

1. Good for patient
2. Better options for residents and families
3. Dignity for patient
4. Need for education
5. Nurses role to provide palliative care
6. Wishes of family and residents need to be paramount
7. Range of therapies which can benefit residents
8. Nurses are afraid of stepping out of line
9. Fear of litigation
10. Palliative care is essential
11. Doctors need to understand palliative care
12. Residents should be kept pain free
13. Palliative care considers psychological needs
14. Palliative care considers spiritual needs
15. Needs support from peers for the resident
16. Palliative care shouldn't hurry or prolong death
17. Patients shouldn't be transferred to acute care hospitals
18. Family needs to be involved
19. Palliative care is challenging
20. Palliative care is compassionate
21. Quality of life is better
22. Palliative care needs professionals
23. Palliative care is worthless as treatment plan
24. Residents shouldn't be overmedicated
25. Residents should be encouraged to talk about their fears
26. Staff needed to carry out palliative care
27. More funding needed for palliative care
28. Palliative care needs special type of carer

29. Nurses get frustrated and stressed
30. Research needed into palliative care
31. The elderly are discriminated against
32. The elderly suffer discomfort
33. Palliative care is inadequate in nursing homes
34. Palliative care offers special care to residents and families
35. Hospitals undervalue nursing homes
36. Patients should not be forced into an acute setting
37. Palliative care should be in all settings
38. Expert advice needed on palliative care
39. Staff need counselling during and after giving care
40. Privacy difficult to achieve in some nursing homes
41. Happier nursing homes if there is palliative care available
42. Rewarding for staff
43. Palliative care is a basic human right
44. Communication is the basis of palliative care
45. Multidisciplinary
46. Skills needed for grief counselling for residents and for families
47. Negative aspects for families and they do nothing for resident
48. Not right place for palliative care
49. Palliative care is time consuming
50. Buildings maintained and are bright and pleasant
51. Palliative care is a lazy way
52. Palliative care divides health carers because of their own beliefs
53. Palliative care is confused with euthanasia
54. Cleanliness
55. Misunderstanding
56. Familiarity with residents and staff
57. Becoming too politicised

Summary of Emotions

1. Inadequate
2. Fulfilled
3. Sad
4. Relieved
5. Accepting
6. Satisfied
7. Comfortable
8. Good
9. Helping
10. Assisting relatives to come to terms with losing a loved one
11. Angry
12. Resolute
13. Inspired
14. Compassionate
15. Protective
16. Encouraged
17. Useful
18. Challenged
19. Supportive
20. Frustrated
21. Rewarded
22. Proud
23. Disappointed
24. Hopeful
25. Anxious
26. Vulnerable
27. Interested
28. Happy

29. Isolated
30. Amazed
31. Helpless
32. Dissatisfied
33. Uplifted
34. Humiliated
35. Upset
36. Annoyed
37. Sincere
38. Empathy
39. Loving
40. Emotional
41. Sympathetic
42. Consciences
43. Responsible
44. Caring
45. Concerned
46. Fear
47. Depressed
48. Self conscious
49. Ill at ease
50. Unfulfilled
51. Thankful
52. Powerless
53. Worthwhile
54. Justified
55. Sentimental
56. Aware
57. Tired
58. Humble

- 59. Respect
- 60. Sense of humour
- 61. Guilty
- 62. Repulsed
- 63. Competent